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VETERANS' OMNIBUS HEALTH CARE ACT
OF 1976

REPORT
OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

TO ACCOMPANY

S. 2908



SEPTEMBER 3 (legislative day, AUGUST 27), 1976.—Ordered to be printed
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(II)

94th Congress
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VETERANS' OMNIBUS HEALTH CARE ACT OF 1976

SEPTEMBER 3 (legislative day, AUGUST 27), 1976.—Ordered to be printed
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Mr. CRANSTON (for Mr. HARTKE), from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany S. 2908]

The Committee on Veterans' Affairs, to which was referred the bill (S. 2908) to amend title 38, United States Code, to improve the quality of hospital care, medical services, and nursing home care in Veterans' Administration health care facilities; to require the availability of comprehensive treatment and rehabilitative services and programs for certain disabled veterans suffering from alcoholism, drug dependence, or alcohol or drug abuse disabilities; to make certain technical and conforming amendments; and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute and recommends that the bill, as amended, do pass.

COMMITTEE AMENDMENT

The amendment is as follows:

Strike out all after the enacting clause as follows:

■That this Act may be cited as the "Veterans Omnibus Health Care Act of 1976".

■TITLE I—GENERAL VETERANS HEALTH CARE AND DEPARTMENT OF MEDICINE AND SURGERY AMENDMENTS

■SEC. 101. Section 111 of title 38, United States Code, is amended by inserting at the end thereof the following new subsection:

■“(e) (1) In carrying out the purposes of this section, the Administrator, in consultation with the Administrator of General Services, the Secretary of Transportation, the Comptroller General of the United States, and representatives of organizations of veterans, shall conduct periodic investigations of the actual cost of travel (including lodging and subsistence) to beneficiaries while traveling to or from a Veterans' Administration facility or other place pursuant to the provisions of this section, and the estimated cost of alternative modes of travel,

including public transportation and the operation of privately owned vehicles. The Administrator shall conduct such investigations not less often than annually and immediately following any alteration in the rates described in clause (C) of this paragraph, and, in any event, immediately following the enactment of this subsection, and, based thereon, shall determine rates of allowances or reimbursement to be paid under this section; but in no event shall such rates provide for reimbursement of privately owned vehicle travel costs unless public transportation is not reasonably accessible or would be medically inadvisable except with respect to a veteran receiving medical services under subsection (a) or (f) (2) of section 612 of this title, nor shall reimbursement exceed the actual expense incurred by the veteran as certified by the veteran. In conducting these investigations and determining such rates, the Administrator shall review and analyze among other factors—

["(A) (i) depreciation of original vehicle costs;

["(ii) gasoline and oil costs;

["(iii) maintenance, accessories, parts, and tires;

["(iv) insurance; and

["(v) State and Federal taxes;

["(B) the availability of and time required for public transportation; and

["(C) the per diem rates, mileage allowances, and expenses of travel authorized under sections 5702 and 5704 of title 5 for employees of the United States traveling on official business.

["(2) Before determining rates of allowances or reimbursement provided for in this section, and not later than sixty days after any alteration in the rates described in clause (C) of paragraph (1) of this subsection, and, in any event, not later than sixty days after the enactment of this subsection, the Administrator shall—

["(A) submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing the rates the Administrator proposes to establish or continue with a full justification therefor in terms of each of the factors set forth in paragraph (1) of this subsection; and

["(B) proceed with a notice of proposed rulemaking in accordance with the procedures set forth in section 553 of title 5, without regard to the exceptions set forth in subsection (d) of such section, including publication in the Federal Register of the proposed rates and the full justification therefor required under clause (A) of this paragraph.

The justification provided under this paragraph shall specify the extent to which and the full reasons why the proposed rates would differ from the rates in effect under sections 5702 and 5704 of title 5 for employees of the United States traveling on official business."

["Sec. 102. Section 601 of title 38, United States Code, is amended by—

["(1) redesignating paragraphs (2) through (7) as paragraphs (3) through (8), respectively, and inserting after paragraph (1) the following new paragraph (2):

["(2) The term 'veteran', with respect to furnishing hospital care and medical services under this chapter for a service-connected disability, includes (except as otherwise provided in section 3103 of this title) a person who served in the active military, naval, or air service and who was discharged or released therefrom with other than a dishonorable discharge."

["(2) amending paragraph (6) (as redesignated by clause (1) of this section) by—

["(A) inserting "and rehabilitative services" immediately after "medical services" in subclause (i) of clause (A);

["(B) striking out clause (B) and the semicolon and "and" following such clause, and redesignating clause (C) as (B); and

["(C) inserting "and" after the semicolon at the end of clause (A);

["(3) amending paragraph (7) (as redesignated by clause (1) of this section) to read as follows:

["(7) The term 'medical services' includes, in addition to medical examination, treatment, and rehabilitative services—

["(A) optometrists' and podiatrists' services, surgical services, dental services and appliances as authorized in section 612 (b), (c), (d), and (e) of this title, and (except under the conditions described in section 612 (f) (1) (A) of this title), wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appli-

ances, and such other supplies or services (including the maintenance of patient drug profiles, patient drug monitoring, and drug utilization education) as the Administrator determines to be reasonable and necessary ;

["(B) such home health services as the Administrator determines to be necessary or appropriate for the effective and economical treatment of a disability of a veteran (including only such improvements and structural alterations as are of a minor nature and are necessary to assure the continuation of treatment or provide access to the home or to essential lavatory and sanitary facilities) ; and

["(C) such mental health services, consultation, professional counseling, and training of the members of the immediate family or legal guardian of a veteran, or, in the case of a veteran who has no immediate family members or legal guardian, the person in whose household such veteran certifies an intention to live, as may be necessary or appropriate to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, (i) necessary expenses of transportation if such family member or person is unable to defray such expenses, or (ii) necessary expenses of transportation and subsistence of such family member or person in the case of a veteran who is receiving care for a service-connected disability or in the case of a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title).

For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title shall be eligible for the same medical services as a veteran." ;

["(4) amending paragraph (8) (as redesignated by clause (1) of this section) to read as follows :

["(8) The term 'domiciliary care' includes necessary medical services and rehabilitative services, and, in the case of veterans who are unable to defray the expense of transportation, transportation and incidental expenses." ; and

["(5) inserting at the end of such section the following new paragraph (9) :

["(9) The term 'rehabilitative service' means those professional services (including appropriate vocational guidance) or treatment programs (other than those types of vocational rehabilitation services provided under chapter 31 of this title) necessary to restore the physical, mental, and psychological functioning of an ill or disabled person."

["Sec. 103. Section 602 of title 38, United States Code, is amended by striking out "an active" and inserting in lieu thereof "a".

["Sec. 104. (a) Subchapter I of chapter 17 of title 38, United States Code, is amended by inserting after section 602 the following new section :

["§ 603. Presumption relating to internment as prisoner of war

["For the purposes of this chapter, the disability of a veteran who was for more than six months a prisoner of war, as specified in section 312(c) of this title, which disability, on the basis of sound medical judgment, could be attributable to or aggravated by such internment, shall be deemed to have been incurred in the active military, naval, or air service, unless the Administrator finds such claim without merit based on clear and convincing evidence."

["(b) The table of sections at the beginning of chapter 17 of title 38, United States Code, is amended by inserting

["603. Presumption relating to internment as prisoner of war."

below

["602. Presumption relating to psychosis."

["Sec. 105. (a) Section 612 of title 38, United States Code is amended by—
Code is amended by—

["(1) inserting after the first sentence of subsection (a) the following new sentence: "The Administrator may also furnish to such veterans such home health services as the Administrator finds to be necessary or appropriate for the effective and economical treatment of such disability (including only such improvements and structural alterations as are necessary to assure the continuation of treatment for such disability or to provide access to the home or to essential lavatory and sanitary facilities).";

["(2) inserting in clause (4) of subsection (b) "(A)" after disability and inserting a comma and "or (B) for which such veteran is receiving treatment (not including routine dental care)" before the semicolon ;

[(3) striking out "or" at the end of such clause (4); and redesignating clause (5) as clause (6) and inserting the following new clause after clause (4) in subsection (b):

["(5) which is a non-service-connected condition or disability of a veteran for which (A) treatment was begun while such veteran was receiving hospital care under this chapter and such services and treatment are reasonably necessary to complete such treatment; or (B) emergency care is necessary but only to the extent required to relieve pain or control infection, or both, and not to include major restoration, prostheses, or therapy; or";

[(4) inserting after "Administrator" in subsection (f) a comma and "within the limits of Veterans' Administration facilities,";

[(5) inserting in clause (1)(A) of subsection (f) "(to the extent that facilities are available)" after "or" the first place it appears;

[(6) inserting before the semicolon at the end of clause (1)(B) of subsection (f) "(for a period not in excess of twelve months after discharge from in-hospital treatment, except where the Administrator finds (i) that a longer period is required by virtue of the disability being treated, and (ii) with respect to private facilities for which the Administrator contracts, that alternative Federal reimbursement is not reasonably available to defray substantially the costs of such treatment)";

[(7) striking out "80" and inserting in lieu thereof "50" in clause (2) of subsection (f); and

[(8) inserting at the end thereof the following new subsection:

["(i) Not later than ninety days after the date of enactment of this subsection, the Administrator shall prescribe regulations to ensure that the highest priority in furnishing medical services under this section shall be accorded as follows, except in the case of medical emergencies which pose a serious threat to life or health:

["(1) To any veteran for a service-connected disability;

["(2) To any veteran described in clause (2) of subsection (1) of this section;

["(3) To any veteran with a disability rated as service-connected; and

["(4) To any veteran being furnished medical services under subsection (g) of this section.".

[(b) Not later than one year after the date of enactment of this section, and annual thereafter, the Administrator shall report to the Congress on the results of the regulations adopted to carry out the amendment made by subsection (a) (8) of this section.

SEC. 106. (a) Subchapter II of chapter 17 of title 38, United States Code, is amended by inserting after section 612 the following new section:

["§ 612A. Eligibility for readjustment professional counseling

["The Administrator is authorized to furnish readjustment professional counseling and to make a general physical, mental, and psychological assessment in connection therewith (including the provision of appropriate counseling, mental health services (as specified in section 601(7)(C) of this title) and referral services with respect thereto) for any veteran who served after August 4, 1964, and who requests assistance with readjustment problems within a period not to exceed four years after the date of such veteran's discharge or release from service, or two years after the enactment of this section, whichever is later. Any hospital care and other medical services deemed necessary as a result of such assessment shall be furnished in accordance with the eligibility criteria otherwise set forth in chapter 17 of this title (including section 611(b) thereof), and where a particular veteran is not eligible for necessary care or services, the Administrator shall provide referral services to assure, to the maximum extent practicable, that such care or services are provided from sources outside the Veterans' Administration. The Chief Medical Director shall provide for such training of professional paraprofessional, and lay personnel as is necessary to carry out this section effectively, and shall make maximum utilization of the services of paraprofessionals, voluntary (without compensation) workers, and veteran students (under section 1685 of this title) in initial intake and screening activities. The Administrator, in cooperation with the Secretary of Defense, shall take appropriate action, as provided in section 241 of this title, to ensure that all veterans eligible for assistance under this section are advised of their eligibility for such assistance and are encouraged to take full advantage thereof.".

[(b) The table of sections at the beginning of such chapter is amended by inserting

"612A. Eligibility for readjustment professional counseling."
below

["612. Eligibility for medical treatment."].

[SEC. 107. Subsection (a) of section 613 of title 38, United States Code, is amended by amending clause (2) to read as follows:

["(2) the widow or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability,"].

[SEC. 108. (a) Section 618 of title 38, United States Code, is amended by—

[(1) striking out "The" where it first appears and inserting in lieu thereof "(a) In providing rehabilitative services under this chapter, the";

[(2) striking out "hospitals and domiciliaries" and inserting in lieu thereof "health care facilities"; and

[(3) inserting the following new subsections:

["(b) (1) In providing rehabilitative services under this chapter, the Administrator, upon the recommendation of the Chief Medical Director, may enter into arrangements with private industry or other sources outside the Veterans' Administration to provide for therapeutic work for remuneration for patients and members in Veterans' Administration health care facilities.

["(2) Notwithstanding any other provision of law, the Administrator may also provide rehabilitative services under this subsection through arrangements with nonprofit entities to provide or provide for such therapeutic work for such patients. The Administrator shall establish appropriate fiscal, accounting, management, recordkeeping, and reporting requirements with respect to the activities of any such nonprofit entity in connection with such arrangements.

["(c) (1) There is hereby established in the Treasury of the United States a revolving fund known as the Veterans' Administration Special Therapeutic and Rehabilitation Activities Fund (hereinafter called the 'fund') for the purpose of carrying out the provisions of subsection (b) of this section. Such amounts of the fund as the Administrator may determine to be necessary to establish and maintain operating accounts for the various rehabilitative services activities may be deposited in checking accounts in other depositories selected or established by the Administrator.

["(2) All funds received by the Veterans' Administration under arrangements made under subsection (b) of this section, or by nonprofit entities described in paragraph (2) of such subsection, shall be deposited in the fund, and the Administrator shall pay out of the fund moneys to participants at such productivity rates (not less than the wage rates specified in the Fair Labor Standards Act (29 U.S.C. 201 et seq.) and regulations prescribed thereunder for work of similar character) as the Administrator shall prescribe in regulations in accordance with applicable law and regulations.

["(3) Any funds in the National Service Life Insurance Fund continued under section 720 of this title (hereinafter in this subsection referred to as the 'NSLI Fund') shall be available to the Administrator and shall be set aside by the Administrator as may be necessary to maintain the fund established by this section at an adequate level to carry out the purposes of subsection (b) of this section. Any such funds set aside shall be considered as investments of the NSLI Fund and while so set aside shall bear interest at a rate not less than the rate paid by the Secretary on other Treasury notes and obligations held by the NSLI Fund at the time such funds are set aside.

["(4) The Chief Medical Director shall prepare, for inclusion in the annual report submitted to Congress under section 214 of this title, a description of the scope and achievements of activities carried out under this section (including pertinent data regarding productivity and wage rates) during the prior twelve months, and an estimate of the needs of the program of therapeutic and rehabilitation activities to be carried out under this section for the ensuing fiscal year. Any balance in the fund at the end of the fiscal year in excess of the estimated requirements for the ensuing fiscal years shall be covered into the Treasury to pay the accrued interest and repay the principal on any NSLI Fund obligations set aside to the fund, and, in the event all such obligations have been met, shall be credited to the Veterans' Administration medical care appropriation.

["(d) In providing rehabilitative services under this chapter, the Administrator shall take appropriate action to make it possible for the patient to take maximum advantage in treatment of a prolonged nature under this chapter, 31, 34, or 35 of this title, and, if the patient is still receiving treatment of a prolonged nature under this chapter, the provision of rehabilitative services under this chapter shall be continued during, and coordinated with, the pursuit of education and training under such chapter 31, 34, or 35.

["(e) The Administrator shall prescribe regulations to ensure that the priorities set forth in section 612(i) of this title shall be applied, insofar as practicable, to participation in therapeutic and rehabilitation activities carried out under this section."

["(b)(1) The Administrator is authorized to settle claims made by the Veterans' Administration against any private nonprofit corporation organized under the laws of any State, for the use of Veterans' Administration facilities and personnel in work projects as a part of a therapeutic or rehabilitation program for patients and members in Veterans' Administration health care facilities, and to execute a binding release of all claims by the United States against any such corporation, in such amounts, and upon such terms and conditions as he deems appropriate.

["(2) For the purposes of this section, notwithstanding section 484 of title 31, or any other law, the Administrator may utilize any funds received under any settlement made pursuant to subsection (a) for any purpose agreed upon by the Administrator and such corporation.

["SEC. 109. (a) Section 620 of title 38, United States Code, is amended by—

["(1) inserting in subsection (a) "and except as provided in subsection (e)" after "subsection (b)";

["(2) striking out "40 per centum" and inserting in lieu thereof "45 per centum" in clause (ii) of subsection (a);

["(3) inserting before the period at the end of clause (ii) of subsection (a) a comma and "or not to exceed 50 per centum of such cost in geographical areas as determined necessary by the Administrator, upon recommendation of the Chief Medical Director, to provide adequate care"; and

(4) inserting at the end thereof the following new subsection:

["(e) For the purposes of this section, the term 'nursing home care' includes intermediate care, as determined by the Administrator in accordance with regulations which the Administrator shall prescribe. The cost of intermediate care for purposes of payment by the United States pursuant to subsection (a) (ii) of this section shall be determined by the Administrator except that the rate of reimbursement shall be commensurately less than that provided for nursing home care (as defined in section 101(28) of this title)."

["SEC. 110. (a) Subsection (b) of section 624 of title 38, United States Code, is amended to read as follows:

["(b) The Administrator may furnish necessary hospital care and medical services to any veteran for any service-connected disability if the veteran (1) is a citizen of the United States sojourning or residing abroad, or (2) is in the Republic of the Philippines, Canada, or Mexico."

["(b) Subchapter V of chapter 17 of title 38, United States Code, is amended as follows:

["(1) Section 641 is amended to read as follows:

["§ 641. Criteria for payment

["(a) Subject to the limitation in subsection (b) of this section, the Administrator shall pay each State at the per diem rate of—

["(1) \$5.50 for domiciliary care,

["(2) \$8 for nursing home care, and

["(3) \$11 for hospital care,

for each veteran receiving such care in a State home, if such veteran is eligible for such care in a Veterans' Administration health care facility under this title.

["(b) No payment shall be made with respect to any veteran under this section in excess of one-half of the cost of the veteran's care in such State home. For the purposes of this section and consistent with the limitation in the preceding sentence, the Administrator shall apply the definition of nursing home care set forth in section 5031(5) with respect to determining the rate of per diem payable for any veteran receiving care in a State home in any State described in such section."

[(2) Section 642 is amended by inserting at the end of subsection (a) the following new sentence: "No payment or grant may be made to any home under this subchapter unless such home is determined by the Administrator to meet such standards as he shall prescribe, which standards with respect to nursing home care shall be no less stringent than those prescribed pursuant to section 620(b) of this title."]

[(3) The changes made by paragraph (1) of this subsection in the maximum per diem rates of payment to State homes under section 641(a) of title 38, United States Code, shall be effective as of January 1, 1976.]

[(c) Subchapter III of chapter 81 of title 38, United States Code, is amended as follows:

[(1) Section 5031 is amended by—

[(A) redesignating paragraphs (a), (b), (c), and (d) as (1), (2), (3), and (4), respectively, and inserting after "buildings" where it first appears in paragraph (3) (as so redesignated) "(including buildings not presently used for providing nursing home care)"; and

[(B) inserting at the end thereof the following new paragraph:

["(5) The term 'nursing home care' shall be deemed to include domiciliary care provided in any State in which no Veterans' Administration hospital or domiciliary facility is located."]

[(2) Section 5034 of title 38, United States Code, is amended by—

[(A) striking out "subchapter" the first place it appears and inserting in lieu thereof "section or any amendment to it with respect to such amendment"; and

[(B) inserting at the end thereof the following:

["(3) General standards for the furnishing of nursing home care in facilities which are constructed with assistance received under this subchapter, which standards shall be no less stringent than those standards prescribed by the Administrator pursuant to section 620(b) of this title, except that facilities constructed with assistance received under this subchapter pursuant to the definition in section 5031(5) of this title shall meet such standards as the Administrator shall prescribe. The Administrator may inspect any State facility constructed with assistance received under this subchapter at such times as the Administrator deems necessary."]

[(3) Section 5035 is amended by—

[(A) inserting at the end of clause (4) of subsection (a) "except as provided in subsection (c) of this section,"; and

[(B) inserting before the period at the end of subsection (c) a comma and "and the Administrator shall waive requirements set forth in subsection (a) (4) of this section in the case of an application from any State described in section 5031(5) of this title to the extent that such State provides reasonable assurance that the portion of the facility constructed with assistance received under this subchapter will be used principally for veterans and that not more than such proportion as the Administrator shall deem reasonable (not more than 50 per centum) of the bed occupancy at any one time will consist of patients who are not receiving care as veterans."]

[Sec. 111. (a) Chapter 17 of title 38, United States Code, is amended by inserting at the end thereof the following new subchapter:

["Subchapter VII—Preventive Health Care Program

["§ 660. Purpose

["The purpose of this subchapter is to provide for a preventive health care program under which the Administrator (1) shall ensure the best possible health care for veterans with service-connected disabilities by furnishing them preventive health care services, and (2) may, in connection therewith, carry out a pilot program (including research) on a geographical or other basis to determine the cost-effectiveness and medical advantages of furnishing preventive health care services to veterans and persons eligible for hospital care and medical care and services under this title.

["§ 661. Definition

["For the purposes of this subchapter, the term 'preventive health care services' may include, but is not limited to, periodic medical and dental examinations; patient education and awareness heightening techniques; maintenance of drug use profiles, patient drug monitoring, and drug utilization education;

mental health preventive services (including family counseling); substance (including tobacco) abuse prevention measures; immunizations against infectious disease; prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature; genetic counseling concerning inheritance of genetically determined diseases; routine vision testing and eye care services; and nutrition education and counseling services. Such term may also include periodic re-examination of likely target populations (high-risk groups) for selected diseases and for functional decline of sensory organs, together with attendant appropriate remedial intervention, and such other medical services as may be necessary for providing effective and economical preventive health care.

["§ 662. Preventive health care services; pilot program

["(a) The Administrator, under regulations which the Administrator shall prescribe, shall furnish, on an inpatient or ambulatory basis, such preventive health care services as are feasible and appropriate to any veteran in connection with the treatment of a service-connected disability and to any veteran described in section 612(f) (2) of this title.

["(b) In connection with preventive health care services furnished under subsection (a) of this section, the Administrator, under regulations which the Administrator shall prescribe, may carry out a pilot program (including research) to demonstrate the cost-effectiveness and medical advantages of furnishing, on an inpatient, outpatient, or ambulatory basis, preventive health care services to persons eligible for hospital care and for medical care or services under this title.

["(c) In carrying out the preventive health care program provided for in this subchapter, the Administrator shall utilize interdisciplinary health care teams composed, to the maximum extent feasible, of various professional and paraprofessional personnel, especially public health nurses, psychologists, optometrists, technicians, physician assistants, and expanded-duty dental auxiliaries.

["§ 663. Reports

["The Administrator shall include in the annual report to the Congress required by section 214 of this title a comprehensive report on the administration of this subchapter, including such recommendations for additional legislation as the Administrator deems necessary.

["§ 664. Limitation

["The Administrator may not use the authority provided in subsection (b) of section 662 of this title to furnish preventive health care services after the last day of the tenth fiscal year following the fiscal year in which the subchapter is enacted."

["(b) The table of sections at the beginning of such chapter 17 is amended by inserting at the end thereof the following:

["SUBCHAPTER VII—PREVENTIVE HEALTH CARE PROGRAM

["660. Purpose.

["661. Definition.

["662. Preventive health care services; pilot program.

["663. Reports.

["664. Limitation."

["(c) The amendments made by subsection (a) of this section shall be effective with respect to services furnished on and after January 1, 1977.

["Sec. 112. Subsection (e) of section 1903 of title 38, United States Code, is amended by—

["(1) striking out "or member of the Armed Forces" where it appears and inserting that language after "title" in paragraph (1); and

["(2) inserting at the end thereof the following new paragraph:

["(3) Notwithstanding any other provision of law, the Administrator may obtain, by purchase, lease, gift, or otherwise, any automobile, motor vehicle, or other conveyance deemed necessary to carry out the purposes of this subsection, and may sell, assign, transfer, or convey vehicles to which the Veterans' Administration obtains title for such price and upon such terms as is deemed appropriate, with any proceeds to the Government received therefrom credited to the applicable Veterans' Administration appropriation."

[SEC. 113. (a) Section 3301 of title 38, United States Code, is amended by—

[(1) inserting “(a)” before “All”;

[(2) striking out “follows;” and inserting in lieu thereof “provided in this section.”, and inserting thereafter the following new subsection:

[(b) The Administrator shall make disclosure of such files, records, reports, and others papers and documents as are described in subsection (a) of this section as follows:”;

[(3) redesignating paragraphs (6), (7), (8), and (9) as subsections (c), (d), (e), and (f);

[(4) inserting after “Administrator” in subsection (e) (as redesignated by clause (3) of this subsection) a comma and “except as otherwise specifically provided in this section with respect to certain information,”; and

[(5) striking out subsection (f) (as redesignated by clause (3) of this subsection) and inserting in lieu thereof the following new subsections:

[(f) The Administrator may, pursuant to regulations the Administrator shall prescribe, release the names and addresses of present or former personnel of the Armed Forces, and/or their dependents, (1) to any nonprofit organization if the release is directly connected with the conduct of programs and the utilization of benefits under this title, or (2) to any criminal or civil law enforcement governmental agency or instrumentality charged under applicable law with the protection of the public health or safety if a qualified representative of such agency has made a written request that such names and addresses be provided for an activity authorized by law. Any organization or member thereof or other person who, knowing that the use of names and addresses released by the Administrator pursuant to the preceding sentence is limited to the purposes specified in such sentence, willfully uses such names and addresses for purposes other than those so specified, shall be guilty of a misdemeanor and be fined not more than \$5,000 in the case of a first offense and not more than \$20,000 in the case of any subsequent offense.

[(g) Any disclosure made pursuant to this section shall be made in accordance with the provisions respecting routine uses in section 552a of title 5.”.

[(b) The amendments made by subsection (a) of this section with respect to subsection (f) (as redesignated by subsection (a) of this section) of section 3301 of title 38, United States Code (except for the increase in criminal penalties for a violation of the second sentence of such subsection (f)), shall be effective with respect to names and addresses released on and after October 24, 1972.

[SEC. 114. (a) Subchapter I of chapter 73 of title 38, United States Code, is amended as follows:

[(1) Subsection (b) of section 4106 is amended to read as follows:

[(b)(1) Such appointments as described in subsection (a) of this section shall be for a probationary period of two years, and the record of each person serving under such appointment in the Medical, Dental, and Nursing Services shall be reviewed periodically by a board composed of employees of comparable or higher grade, appointed under this chapter in accordance with regulations which the Administrator shall prescribe. If such board shall find the probationary employee not fully qualified and satisfactory for reasons relating to professional competence or performance, such employee may be separated from the service, or reassigned or be subject to other nondisciplinary action, consistent with continuing the employment of such employee in a capacity in which such employee can effectively function, in accordance with the procedures prescribed in paragraph (2) or (3) of this subsection.

[(2) When it is proposed to take such action as described in paragraph (1) with respect to a probationary employee, such employee shall be entitled to (A) a statement in writing of the reasons therefor and of any proposed finding with respect to professional competence or performance; (B) an opportunity to reply orally or in writing, or both; and (C) assistance (not at Government expense) by a person of the employee's choice with regard to such reply.

[(3) When a board recommends that action be taken as described in paragraph (1) of this subsection, such action shall be taken in accordance with the procedures prescribed in section 4110(e) of this title.

[(4) When it is proposed to take disciplinary action against a probationary employee on grounds which constitute misconduct, such action shall be taken in accordance with the procedures prescribed in section 4110 of this title.”.

[(2) Section 4110 is amended to read as follows:

["§ 4110. Disciplinary boards

["(a) When it is proposed to take disciplinary action on grounds of inaptitude, inefficiency, misconduct, or for other such cause as will promote the efficiency of the service, against any person appointed under section 4104 of this title who has completed the probationary period as provided for in section 4106(b) of this title, or when it is proposed to take disciplinary action on grounds which constitute misconduct against a probationary employee appointed under section 4104(1) of this title or against a resident or intern appointed under section 4114(b) of this title, the Chief Medical Director shall cause to be appointed a disciplinary board which shall operate in accordance with regulations the Administrator shall prescribe.

["(b) Each such board shall consist of not less than three nor more than five employees of comparable or higher grade, appointed under this chapter, but a majority of such board shall be of the same profession as the employee charged. The members of the board shall be selected by the Chief Medical Director.

["(c) The Chief Medical Director shall appoint the chairman of the board who shall be a member of the same profession as the employee charged. A member of the board shall be elected as secretary by a majority of the board. The chairman and secretary shall have authority to administer oaths to persons testifying before the board. The Chief Medical Director may designate or appoint one or more investigators to assist the board in the collection of evidence, and counsel may be appointed to represent the Veterans' Administration.

["(d) Any employee answering to charges before a disciplinary board shall be entitled to (1) specification of charges, (2) a full hearing with opportunity to produce supportive witnesses and confront and cross-examine available witnesses, and (3) representation (not at Government expense) by a person of the employee's choice throughout the procedure prescribed in this section.

["(e) If a disciplinary board determines that any charge is sustained, it shall recommend to the Chief Medical Director such disciplinary action as it deems appropriate, which shall include, but is not limited to, reprimand, suspension without pay, reassignment, reduction in grade, and separation. The Chief Medical Director shall either (1) approve the findings and recommendations of the board, (2) approve such findings and recommendation with modification of the recommendation or exception to the findings, or (3) disapprove such findings and recommendation, and take appropriate action. In the event the Chief Medical Director takes exception to any finding of fact of the board, the Chief Medical Director may refer the matter to the board for reconsideration. If the Chief Medical Director refers the matter to the board for reconsideration and after such reconsideration the Chief Medical Director continues to take exception to any such finding of fact, the Chief Medical Director may make his own independent review of the record before making a final decision on the matter under consideration. The decision of the Chief Medical Director shall be the final agency decision.

["(f) The Chief Medical Director may, as disciplinary action under subsection (e) of this section, order the reassignment of any employee charged under this section. The Chief Medical Director may also reassign an employee for the good of the service and such reassignment shall not, in itself, entitle such reassigned employee to a hearing under this section. When a reassignment is so directed for the good of the service by the Chief Medical Director and results in a reduction in grade, salary, or relative standing in the Department of Medicine and Surgery of the transferred employee who has completed the probationary period as prescribed by section 4106(b) of this title, such employee shall be entitled to the procedures prescribed in this section. When an employee alleges that a transfer directed for the good of the service is disciplinary in nature, the employee shall be entitled to the procedures prescribed by the Administrator to determine employee grievances. If such allegation is sustained in such grievance procedure, the employee shall be entitled to the procedures prescribed in this section. For the purposes of this section, the term 'reassignment' means the transfer of an employee from one duty station to another or from one set of responsibilities to another, within the Department of Medicine and Surgery."

["(3) Subsection (b) of section 4114 is amended by redesignating paragraphs (2) and (3) as paragraphs (3) and (4) and by inserting the following new paragraph (2):

["(2) In order to carry out the purposes of paragraph (1) of this subsection, the Chief Medical Director shall cause to have appointed House Staff Review

Committees, pursuant to regulations prescribed by the Administrator, which shall periodically review the academic and professional performance and progress of persons appointed under paragraph (1) of this subsection. When it is proposed to take action, such as reduction in grade, suspension without pay, or separation with respect to a person appointed under such paragraph for reasons relating to professional or academic competence or performance, such person shall be entitled to (A) a statement in writing of the reasons therefor and of any proposed finding with respect to professional or academic competence or performance, and (B) an opportunity to reply orally or in writing, or both, to the House Staff Review Committee. When it is proposed to separate a person appointed under paragraph (1) of this subsection from the training program on grounds which constitute misconduct, such action shall be taken in accordance with the procedures prescribed in section 4110 of this title."

[(b) The amendment made by subsection (a) of this section with respect to the period of probationary service under section 4106 of title 38, United States Code, shall become effective—

[(1) as to probationary employees who, on the date of enactment of this Act, have served eighteen months or more of their probationary period, one hundred and eighty days after such enactment date;

[(2) as to probationary employees who, on such enactment date, have served less than eighteen months of their probationary period, upon such date.

[Sec. 115. Section 4107 of title 38, United States Code, is amended by—

[(1) inserting at the end of subsection (e) the following new paragraph :

["(10) The provisions of this subsection shall apply, in lieu of the provisions of sections 5542, 5543, 5545 (a), (b), and (c), and 5546 of title 5 with respect to any person employed in the Department of Medicine and Surgery, except for physicians and dentists, whose principal responsibilities, as determined by the Chief Medical Director pursuant to regulations which the Administrator shall prescribe, relate directly to patient care."; and

[(2) inserting at the end thereof the following new subsection :

["(g) When the Administrator finds such action to be necessary in order to obtain or retain the services of health care personnel to provide hospital care and medical services for veterans, the Administrator, notwithstanding any other provision of law, shall increase the minimum or maximum rates of basic pay authorized under this chapter or title 5, on a nationwide, local, or other geographical basis, for one or more grades or for one or more medical, dental, or health care fields within the grades, to (1) provide rates of basic pay commensurate with competitive pay practices in the same occupation or in order to achieve internal alignment of rates of basic pay within the Department of Medicine and Surgery, or (2) meet staffing requirements at Veterans' Administration facilities. Any such increase in the minimum rate of basic pay for any grade may not exceed the maximum rate prescribed pursuant to law for such grade. Any such increase in the maximum rate of basic pay for any grade may not exceed in corresponding amount, the rate provided for in the statutory range for that grade, subject to the limitation on the rate of basic pay fixed by administrative action set forth in section 5363 of title 5."

[Sec. 116. Subsection (6) (1) of section 4114 of title 38, United States Code, is amended by inserting "(which may be established retroactively based on changes in such customary amount and terms)" after "pay".

[Sec. 117. (a) Chapter 73 of title 38, United States Code, is amended by inserting at the end thereof the following new subchapter :

["Subchapter III—Protection of Patient Rights

["§ 4131. Informed consent

["The Administrator, upon the recommendation of the Chief Medical Director and pursuant to the provisions of section 4134 of this title, shall prescribe regulations establishing procedures to ensure that all medical and prosthetic research carried out and, to the maximum extent practicable, all patient care furnished under this title shall be carried out only with the full and informed consent of the subject/patient or a representative thereof, as appropriate.

["§ 4132. Confidentiality of certain medical records

["(a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to drug abuse, alcoholism or alcohol abuse, or sickle-cell anemia education, training, treatment, rehabilitation, or research, which is carried out by or for the Veterans' Administration under this title shall, except as provided in subsection (e) of this section, be confidential and be disclosed (section 3301 of this title to the contrary notwithstanding) only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

["(b) (1) The content of any record referred to in subsection (a) of this section may be disclosed by the Administrator in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed by the Administrator pursuant to section 4134 of this title.

["(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives written consent, the content of such record may be disclosed by the Administrator as follows:

["(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

["(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

["(C) If authorized by an appropriate order of a United States court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

["(3) In the event that the patient who is the subject of any record referred to in subsection (a) of this section is deceased, the content of any such record may be disclosed by the Administrator only upon the prior written request of the next of kin, executor, administrator, or other personal representative of such patient and only if the Administrator determines that such disclosure is necessary for such survivor to obtain benefits to which such survivor may be entitled, including the pursuit of legal action, but then only to the extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed pursuant to section 4134 of this title.

["(c) Except as authorized by a court order granted under subsection (b) (2) (C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

["(d) The prohibitions of this section continue to apply to records concerning any person who has been a patient, irrespective of whether or when such person ceases to be a patient.

["(e) The prohibitions of this section do not apply to any interchange of records—

["(1) within and among those facilities of the Veterans' Administration furnishing health care to veterans, or

["(2) between such facilities and the Armed Forces.

["(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

["§ 4133. Nondiscrimination in the admission of alcohol and drug abusers to Veterans' Administration health care facilities

["Alcohol and drug abusers who are suffering from medical disabilities shall not be discriminated against in admission or treatment, solely because of their

alcohol or drug abuse or dependence, by any Veterans' Administration health care facility. The Administrator, pursuant to the provisions of section 4134 of this title, shall prescribe regulations for the enforcement of this nondiscrimination policy with respect to the admission and treatment of such alcohol and drug abusers.

["§ 4134. Coordination; reports

["(a) Regulations prescribed pursuant to section 4131 of this title, section 4132 of this title with respect to the confidentiality of alcohol and drug abuse medical records, and section 4133 of this title, shall, to the maximum extent feasible consistent with other provisions of this title, make applicable the regulations governing—

["(1) human experimentation and informed consent prescribed by the Secretary of Health, Education, and Welfare, based on the recommendations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, established by section 201 of the National Research Act, as amended (Public Law 93-348; 88 Stat. 348), and

["(2) (A) the confidentiality of drug and alcohol abuse medical records, and (B) the admission of drug and alcohol abusers to private and public hospitals, prescribed pursuant to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended (42 U.S.C. 4551 et seq.), and the Drug Abuse Office and Treatment Act of 1972, as amended (21 U.S.C. 1101 et seq.),

to the conduct of research and to the provision of hospital care, nursing home care, domiciliary care, and medical services under this title. Such regulations may contain such definitions, and may provide for such safeguards and procedures (including procedures and criteria for the issuance and scope of court orders under section 4132(b)(2)(C) of this title) as are necessary to prevent circumvention or evasion thereof, or to facilitate compliance therewith. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary of Health, Education, and Welfare, and, as appropriate, the Director of the Special Action Office on Drug Abuse Prevention (or any successor authority), in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they and the Administrator prescribe.

["(b) Not later than sixty days after the date of enactment of this subsection, the Administrator shall submit to the appropriate committees of the House of Representatives and the Senate a full report with respect to the regulations (including guidelines, policies, and procedures thereunder) prescribed pursuant to subsection (a) of this section. Such report shall include (1) an explanation of any inconsistency between such regulations and the regulations of the Secretary referred to in such subsection (a), (2) an account of the extent, substance, and results of consultations with the Secretary (or Director, as appropriate) respecting the prescribing and implementation of the Administrator's regulations, and (3) such recommendations for legislation and administrative actions as the Administrator determines are necessary and desirable. The Administrator shall timely publish such report in the Federal Register."

["(b) The analysis at the beginning of such chapter is amended by adding at the end thereof:

["SUBCHAPTER III—PROTECTION OF PATIENT RIGHTS

["4131. Informed consent.

["4132. Confidentiality of certain medical records.

["4133. Nondiscrimination in the admission of alcohol and drug abusers to Veterans' Administration health care facilities.

["4134. Coordination; reports."

["(c) The following provisions of law are superseded by the provisions of the amendments made by section 4134 of this title:

["(1) Subsection (a) of section 321 of the Drug Abuse Office and Treatment Act of 1972 (as added by section 121(a) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (Public Law 93-282; 88 Stat. 130; 42 U.S.C. 4581(a))).

["(2) Paragraph (2) of subsection (b) of section 407 of such 1972 Act (as added by section 6(a) of — of 1976 (Public Law 94—; Stat.)).

["(3) Subsection (h) of section 408 of such 1972 Act (as added by section 303(a) of such 1974 Act (88 Stat. 137)).

[(4) Subsection (c) of section 303 of such 1974 Act (88 Stat. 139).]

[(5) Subsection (h) of section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (as added by section 122 of such 1974 Act (88 Stat. 131; 42 U.S.C. 4582(h)))].

[(6) Subsection (c) of section 122 of such 1974 Act (88 Stat. 133).]

[(7) Subsection (b) of section 6 of such 1976 Act (Stat.).]

[Sec. 118. Section 4123 is amended by adding at the end thereof the following new sentence: "Any proceeds to the Government received therefrom shall be credited to the applicable Veterans' Administration medical appropriation.".]

[SEC. 119. Chapter 75 of title 38, United States Code, is amended as follows:

[(a) Section 4204 is amended by—

[(1) inserting "(a)" before "To"; and

[(2) inserting at the end thereof the following new subsection:

["(b) Without regard to fiscal year limitations, obligations may be incurred against anticipated, budgetary resources of the Service revolving fund in such amounts and for such periods as the Administrator may determine to be necessary to maintain and continue operations without incurring over-obligations at any time during the fiscal year.".]

[(b) Section 4206 is amended by—

[(1) striking out "year" the first place it appears in the first sentence and the second place it appears in the second sentence and inserting in lieu thereof "years"; and

[(2) inserting at the end thereof the following new sentence: "In determining estimated requirements, the Service may provide for capital improvements to canteen facilities, including those which are constructed and become a part of the building or structure.".]

[SEC. 120. Subsection (a) (3) of section 5001 of title 38, United States Code, is amended by striking out "eight thousand beds in the fiscal year ending June 30, 1974," and inserting in lieu thereof "ten thousand beds in fiscal year 1977".]

[SEC. 121. Subchapter IV of chapter 81 of title 38, United States Code, is amended as follows:

[(a) Section 5053 is amended by—

[(1) inserting in subsection (a) in the material before clause (1) and in clauses (1) and (2) thereof "or other" after "specialized" each place it appears; and

[(2) inserting at the end thereof the following new subsections:

["(d) The Administrator shall not enter into any arrangement under clause (2) of subsection (a) of this section, or any renewal of any arrangement entered into under such clause, with respect to the use of other medical resources in a Veterans' Administration health care facility unless, at least thirty days prior thereto, the Administrator has published in the Federal Register the subject matter and specific justification for the proposed contract or agreement. The contract or other agreement providing for any such arrangement shall (1) specify that any veteran eligible for treatment under this title shall continue to be accorded priority in furnishing care and services in the Veterans' Administration facility involved, according highest priority to those veterans described in section 612(i) of this title, (2) specify that any veteran treated in a community health care facility under this section shall be referred for such treatment in accordance with the priorities in such section 612(i), (3) be for a period of time not in excess of one year, and (4) not be renewed (and no new such arrangement shall be entered into with the same medical facility) until a full report on the effect of such prior arrangement (including the effect on the provision of hospital care and medical services to eligible veterans and persons under this chapter) has been transmitted to the Committees on Veterans' Affairs of the House of Representatives and the Senate.

["(e) When a Veterans' Administration health care facility provides hospital care or medical services, pursuant to a contract or agreement authorized by this section, to an individual who is not an eligible veteran and who is entitled to hospital or medical insurance benefits under subchapter XVIII of chapter 7 of title 42, such benefits, notwithstanding any condition, limitation or other provision in that title which would otherwise preclude such payment, shall be paid in accordance with rates prescribed by the Secretary of Health, Education, and Welfare, after consultation with the Administrator, to such facility therefor or, if the contract or agreement so provides, to the community health care facility which is a party to the contract or agreement.".]

[(b) Section 5054 of title 38, United States Code, is amended by inserting at the end of subsection (b) the following new sentence: "Any proceeds to the Government received therefrom shall be credited to the applicable Veterans' Administration appropriation."

[(c) Subsection (c)(1) of section 5055 is amended by striking out "1975" and inserting in lieu thereof "1980".

[(d) Section 5056 is amended by—

[(1) amending the catchline to read as follows:

["§ 5056. Coordination with health services development activities carried out under the National Health Planning and Resources Development Act of 1974"; and

[(2) striking out "title IX" and inserting in lieu thereof "part F of title XVI".

[(e) Insert the following new sections at the end of such subchapter:

["§ 5058. Coordination with programs carried out under title XI of the Social Security Act

["(a) The Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, attempt to coordinate the Professional Standards Review program carried out under part B of title XI of the Social Security Act and the comparable programs carried out by the Department of Medicine and Surgery to assess the quality of patient care in Veterans' Administration health care facilities. Such coordination shall include sharing of information with regard to norms of health care services developed on a regional and national basis and arrangements for joint memberships on entities established by the Department of Medicine and Surgery and entities established under such Act.

["(b) Not later than one year after the date of enactment of this section, and annually thereafter, the Chief Medical Director shall report to the Congress on the effectiveness of such coordination in improving the evaluation of the quality of patient care provided by the Department of Medicine and Surgery and in achieving the purposes of the program carried out under such Act.

["§ 5059. Reports on coordination with other programs

["Not later than three months after the end of each fiscal year, the Chief Medical Director, through the Administrator, shall report to the Congress on all activities (and the results thereof) in which the Chief Medical Director or a designee, as a representative of the Veterans' Administration, has participated, as a result of a statutory requirement or otherwise, in an advisory or coordinating capacity with respect to programs carried out by other departments, agencies, or instrumentalities of the executive branch.".

[(f) The table of sections at the beginning of such chapter is amended by—

[(1) striking out

["5056. Coordination with programs carried out under the Heart Disease, Cancer, and Stroke Amendments of 1965."]

and inserting in lieu thereof

["5056. Coordination with health services development activities carried out under the National Health Planning and Resources Development Act of 1974.";

and

[(2) inserting at the end thereof

["5058. Coordination with programs carried out under title XI of the Social Security Act.

["5059. Reports on coordination with other programs.".

[SEC. 122. Subchapter I of chapter 82 of title 38, United States Code, is amended by—

[(1) redesignating subsections (e) and (f) of section 5070 as subsections (f) and (g), respectively, and inserting the following new subsection (e):

["(e) In carrying out the purposes of this chapter, the Administrator may lease to any eligible institution for such consideration and under such terms and conditions as the Administrator deems appropriate, such land, buildings, and structures (including equipment therein) under the control and jurisdiction of the Veterans' Administration as may be necessary. The three-year limitation on the term of a lease prescribed in section 5012(a) of this title shall not apply with respect to any lease entered into pursuant to this chapter. Any lease entered into pursuant to this chapter may be entered into without regard to the provisions

of section 3709 of the Revised Statutes (41 U.S.C. 5). Notwithstanding section 321 of the Act entitled 'An Act making appropriations for the Legislative Branch of the Government for the fiscal year ending June 30, 1933, and for other purposes', approved June 30, 1932 (40 U.S.C. 303b), or any other provision of law, a lease entered into pursuant to this chapter may provide for the maintenance, protection, or restoration, by the leasee, of the property leased, as a part or all of the consideration of the lease.”;

[(2) inserting at the end of section 5070 the following new subsection: [“(h) Not later than June 30, 1976, and not later than ninety days after the end of each fiscal year thereafter, the Administrator shall submit to the Congress a report on activities carried out under this chapter, including (1) an appraisal of the effectiveness of the programs authorized herein in carrying out their statutory purposes and the degree of cooperation from other sources, financial and otherwise, (2) an appraisal of the contributions of such programs in improving the quantity and quality of physicians and other health care personnel furnishing hospital care and medical services to veterans under this title, (3) a list of the approved but unfunded projects under this chapter and the funds needed for each such project, and (4) recommendations for the improvement or more effective administration of such programs, including any necessary legislation.”];

[(3) striking out paragraph (1) of subsection (a) of section 5073 and redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively; and

[(4) striking out in subsection (a) of section 5083 “subchapter IV of chapter 81 of”.

[SEC. 123. (a) The Chief Medical Director of the Department of Medicine and Surgery of the Veterans' Administration shall carry out or provide for a study to determine the short-range and long-range direction of the hospital and medical program carried out under title 38, United States Code, for eligible veterans and persons with reference to the increasing average age of the eligible veteran population. Not later than twelve months after the date of enactment of this Act, the Chief Medical Director, through the Administrator of Veterans' Affairs, shall submit to the appropriate Committees on Veterans' Affairs of the Senate and House of Representatives a report on the results of such study, including, but not limited to, specific plans for—

[(1) increasing the number of Veterans' Administration hospital, nursing home, intermediate care, and domiciliary beds;

[(2) increasing the program for contracting for such nursing home care (including intermediate and personal care) in community facilities;

[(3) emphasizing education and training of health care personnel specializing in the treatment of elderly persons and diseases and infirmities characteristic of an aging population;

[(4) expanding alternatives to institutional care, including provision of home health (including homemaker and special nutrition) services;

[(5) emphasizing treatment programs particularly suited to meeting the health care needs of an aging population;

[(6) meeting the special architectural, transportation, and environmental needs of an aging population; and

[(7) conducting biomedical and health services research designed to solve geriatric care problems.

[(b) Not later than ninety days after the date of enactment of this Act, the Administrator shall take all appropriate steps to ensure that, to the maximum extent feasible, each individual eligible for new or expanded care and services as a result of the amendments made by this Act is personally notified, in a clear and simple manner, about such new or expanded eligibility and the way to secure such care and services, and shall send copies of all such notification forms to the appropriate committees of the House of Representatives and the Senate, along with a description of how such forms were distributed.

[TITLE II—VETERANS DRUG AND ALCOHOL TREATMENT AND REHABILITATION AMENDMENTS

[SEC. 201. This title may be cited as the “Veterans Drug and Alcohol Treatment and Rehabilitation Act of 1976”.

[SEC. 202. Paragraph (1) of section 601 of title 38, United States Code, is amended by inserting “(including alcoholism and drug dependence)” after “disease”.

[SEC. 203. (a) Subchapter II of chapter 17 of title 38, United States Code, is amended by inserting at the end thereof the following new section :

["§ 620A. Treatment and rehabilitation for alcoholism

["(a) The Congress hereby finds and declares that alcoholism and alcohol abuse are among the most pervasive untreated diseases and disabilities afflicting the Nation, including the veteran population, and that the onset of such conditions often has occurred during military service.

["(b) In order to meet the situation described in subsection (a) of this section, the Administrator, in carrying out the responsibilities to furnish hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, shall carry out specialized medical programs providing inpatient treatment (including treatment of the symptoms of detoxification) and outpatient treatment and rehabilitative services on a nationwide basis to eligible veterans suffering from the disability of alcoholism or alcohol abuse. In carrying out such specialized medical programs, the Administrator (1) shall utilize the most efficacious available models, stressing the utilization in such programs of recovered alcoholic counselors and half-way houses, encounter-style therapeutic communities, and other treatment and rehabilitation modalities, extending beyond the detoxification period and designed to provide for the full recovery of the addict patient and such patient's restoration to society as a productive, self-sufficient citizen, and (2) may utilize either facilities over which the Administrator has direct and exclusive jurisdiction, or other Government or private facilities for which the Administrator contracts in accordance with such regulations as the Administrator shall prescribe.

["(c) The Administrator shall submit annually (as a part of the annual report submitted pursuant to section 214 of this title) a full report on the programs carried out under this section, including the same type of information specified in section 667 of this title."

["(b) The table of sections at the beginning of such chapter is amended by inserting

["620A. Treatment for alcoholism."

below

["620. Transfers for nursing home care."

[SEC. 204. (a) Chapter 17 of title 38, United States Code, is amended by inserting at the end thereof the following new subchapter :

["Subchapter VII—Special Medical Treatment and Rehabilitative Services for Drug Dependence or Drug Abuse Disabilities

["§ 661. Definition

["As used in this subchapter and notwithstanding any other provision of this title, the term 'veteran' includes (except as otherwise provided in section 3103 of this title) a person who served in the active military, naval, or air service and who was discharged or released therefrom with other than a dishonorable discharge.

["§ 662. Treatment and rehabilitative services for veterans suffering from drug abuse disabilities

["(a) The Administrator shall furnish to any veteran with a drug dependence or drug abuse disability such special medical treatment and rehabilitative services and such hospital, nursing home, and domiciliary care (hereinafter in this subchapter collectively referred to as treatment and rehabilitative services) as the Administrator finds to be reasonably necessary to bring about the veteran's recovery and rehabilitation from such disability.

["(b) Such treatment and rehabilitative services shall (1) include, but not be limited to, in addition to those services provided pursuant to section 601 of this title, individual counseling and referral services and crisis intervention, and (2) be provided in hospital, domiciliary, outpatient, and halfway house and other community-based facilities (including satellite facilities located in areas where large numbers of veterans eligible for treatment and rehabilitative services under this subchapter reside) over which the Administrator has direct and exclusive jurisdiction or in other Government or public or private facilities for which the Administrator contracts in accordance with such regulations as the Administrator shall prescribe.

["(c) In providing for treatment and rehabilitative services under this subchapter to any veteran, the Administrator shall offer alternative modalities of treatment based upon the individual needs of such veteran.

["(d) In contracting for treatment and rehabilitative services in facilities outside the Veterans' Administration pursuant to this subchapter, the Administrator shall, wherever feasible, give priority to community-based, multiple-modality, treatment and rehabilitation programs which employ peer group veterans and stress outreach efforts to identify and counsel veterans eligible for treatment and rehabilitative services under this subchapter.

["(e) The Administrator shall, upon receipt of application for treatment and rehabilitative services under this subchapter by any veteran who has been discharged or released from a period of active military, naval, or air service, with other than an honorable or general discharge—

["(1) advise such veteran of the right to apply to the appropriate military, naval, or air service for a review of the nature of such discharge or release for the purpose of correcting the nature of such discharge and thus removing any ineligibility to the receipt of benefits under this title or any other law ;

["(2) advise such veteran of the policy of the Armed Forces with respect to review of the nature of any discharge received in connection with drug use or possession ; and

["(3) advise such veteran of all program benefits under this title and any other law to which such veteran is entitled or would be entitled with a general or honorable discharge.

The Administrator shall offer and, if requested, provide to any veteran within the purview of this subsection such assistance as may be necessary to facilitate the process of preparing and filing an application for a review of the nature of such veteran's discharge or release from a period of active military, naval, or air service.

["(f) (1) The Administrator shall also provide for treatment and rehabilitative services in the case of any veteran eligible therefor under this subchapter who has been charged with, or convicted of, a criminal offense by any court of competent jurisdiction in the United States, who is not confined and who is not required to participate in the treatment and rehabilitation program by any such court.

["(2) The Administrator may also provide for treatment and rehabilitative services to any veteran eligible therefor under this subchapter who is under the jurisdiction of a court of competent jurisdiction as the result of having been charged with, or having been convicted of, a criminal offense and who is required to participate in a treatment and rehabilitation program by such court, but such services may be provided only under such conditions as the Administrator determines will insure that the participation of such veteran in the program in question will not impair the voluntary nature of the treatment and rehabilitative services being provided to other patients in such program.

["§ 663. Outreach and counseling

["(a) The Administrator shall utilize all available resources of the Veterans' Administration, including the use of peer-group veterans, in seeking out and counseling toward treatment and rehabilitation all veterans, especially veterans who served after August 4, 1964, eligible for treatment and rehabilitative services under this subchapter.

["(b) The Administrator shall carry out an affirmative action program, in consultation with the Secretary of Labor and the Chairman of the Civil Service Commission, to (1) urge all Federal agencies, private and public firms, organizations, agencies, and persons to provide appropriate employment and training opportunities for veterans provided treatment and rehabilitative services under this subchapter who have been determined by competent medical authority to be sufficiently rehabilitated to be employable, and (2) provide all possible assistance to the Secretary of Labor in placing such veterans in such opportunities.

["§ 664. Audits by Comptroller General

["The Comptroller General of the United States, or any of his duly authorized representatives, shall have access for the purpose of audit and examination to any books, accounts, records, reports, files, and all other things or property of facilities outside the Veterans' Administration that are pertinent to payments received pursuant to contracts entered into under this subchapter.

["(b) The Comptroller General shall carry out the responsibilities under this section in such a way as to comply with the provisions set forth in section 4132 of this title with respect to medical confidentiality.

["§ 665. Budget requests

["For fiscal year 1977, and for each fiscal year thereafter, there shall be included in the budget required to be submitted to Congress pursuant to section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11), a separate line item showing the estimated expenditures by the Veterans' Administration under this subchapter and under section 620A of this title during such fiscal year for the treatment and rehabilitation of eligible veterans.

["§ 666. Treatment of members of the Armed Forces by the Veterans' Administration

["(a) Any member of the active military, naval, or air service who is determined by the Secretary of the military department concerned to have a drug dependence or drug abuse disability, may, pursuant to such terms as may be mutually agreeable to the Secretary concerned and the Administrator, and subject to the provisions of the Act of March 4, 1915, as amended (31 U.S.C. 686), be transferred to any Veterans' Administration facility within the last ninety days of such member's tour of duty and be provided treatment and rehabilitative services under this subchapter as if such member were a veteran.

["(b) The Administrator shall from time to time make a report to the Secretary concerned as to the progress of the treatment of any member transferred pursuant to the provisions of this section, and the Administrator shall release such member to the Secretary concerned when the Administrator finds that the drug abuse disability of such member is stabilized, or certifies that (1) such member refuses to comply with the terms and conditions of the treatment prescribed, or (2) the treatment which could otherwise be provided will be of no further benefit to such member.

["(c) No member of the active military, naval, or air service shall be transferred to any Veterans' Administration facility pursuant to subsection (a) of this section unless such member requests such transfer in writing for a specified period of time within such member's tour of duty. No such member thereafter transferred shall be retained for treatment by the Administrator beyond such specified period of time within such member's tour of duty unless the member in writing requests treatment for a further specified period of time and such request is approved by the Secretary concerned and the Administrator.

["§ 667. Reports

["Not later than six months after the date of the enactment of this section and thereafter on each February 1, the Administrator shall submit to the appropriate committees of the House of Representatives and the Senate a full report on the implementation of this subchapter and section 620A of this title separately with respect to alcoholism and alcohol abuse, on the one hand, and to drug dependency and abuse on the other, and an evaluation of the effectiveness of alternate treatment and rehabilitation programs provided hereunder and under such section 620A, including (1) the number of veterans and servicemen provided treatment and/or rehabilitative services, (2) the average duration of such treatment and/or services, (3) the estimated percentage of successful rehabilitation and enduring recovery cases, (4) an analysis of successful and unsuccessful rehabilitation experience, (5) a description of outreach, information dissemination, and job development and placement efforts, (6) a full accounting of payments to, and an evaluation of services and programs provided in, facilities outside the Veterans' Administration, (7) experience under the medical confidentiality provisions in section 4132 of this title, (2) plans for new program directions, and (9) such recommendations for legislation as the Administrator deems appropriate."

["(b) The table of sections at the beginning of chapter 17 of title 38, United States Code, is amended by inserting at the end thereof the following:

["SUBCHAPTER VII—SPECIAL MEDICAL TREATMENT AND REHABILITATIVE SERVICES FOR DRUG DEPENDENCE OR DRUG ABUSE DISABILITIES

["Sec.

["661. Definition.

["662. Treatment and rehabilitative services for veterans suffering from drug dependence or drug abuse disabilities.

["663. Outreach and counseling.

["664. Audits by Comptroller General.

["665. Budget requests.

["666. Treatment of members of the Armed Forces by the Veterans' Administration.

["667. Reports.".

[TITLE III—MEDICAL TECHNICAL AND CONFORMING AMENDMENTS

[SEC. 301. This title may be cited as the "Veterans Medical Technical and Conforming Amendments of 1976".

[SEC. 302. Chapter 17 of title 38, United States Code, is amended as follows:

[(a) The title of such chapter is amended by inserting ["NURSING HOME," before "DOMICILIARY".

[(b) Section 601 is amended by—

[(1) striking out "and exclusive" in clause (A) of paragraph (5) (as redesignated by section 102(1) of this Act);

[(2) inserting after "contracts" in clause (C) of paragraph (5) (as so redesignated) "when facilities described in clause (A) or (B) of this paragraph are not geographically accessible or capable of furnishing the care or services required";

[(3) striking out subclause (i) of clause (C) of paragraph (5) (as so redesignated) and inserting in lieu thereof the following subclauses: "(i) hospital care or medical services to a veteran for the treatment of a service-connected disability, a disability for which a veteran was discharged or released from the active military, naval, or air service, or any disability of a veteran described in clause (1) (B) or (2) of section 612(f) of this title; (ii) hospital care for any disability of a veteran which care the Veterans' Administration is not capable of furnishing;" ; and

[(4) redesignating subclauses (ii) and (iii) of clause (C) of paragraph (5) (as so redesignated) as subclauses (iii) and (iv), respectively.

[(c) The title of subchapter II of such chapter is amended by inserting a comma and "Nursing Home," after "Hospital".

[(d) Section 610 is amended by—

[(1) inserting a comma and "nursing home," after "hospital" in the title of such section;

[(2) inserting "or nursing home" after "hospital" in subsection (a) (1) (B); and

[(3) striking out "and exclusive" in subsection (d).

[(e) Subsection (b) (2) of section 610 is amended by striking out "of any war or of service after January 31, 1955," and the comma after "domiciliary care".

[(f) (1) The title of section 611 is amended by striking out "Hospitalization" and inserting in lieu thereof "Care".

[(2) Subsection (b) of section 611 is amended by inserting "or medical services" after "hospital care".

[(g) Section 612 is amended by—

[(1) striking out "Indian wars" and inserting in lieu thereof "Indian Wars" in subsection (e);

[(2) striking out "granted" and inserting in lieu thereof "furnished" in subsection (f) (1) (B); and

[(3) inserting after "Administrator" in subsection (g) a comma and "within the limits of Veterans' Administration facilities".

[(h) Section 616 is amended by striking out "Bureau of the Budget" and inserting in lieu thereof "Office of Management and Budget".

[(i) The title of subchapter III of such chapter is amended by inserting "and Nursing Home" after "Hospital".

[(j) Clauses (1) through (3) of section 621 are amended by inserting a comma and "nursing home," after "hospital" each time it appears.

[(k) Subsection (a) of section 622 is amended by striking out "610(a) (1)" and inserting in lieu thereof "610(a) (1) (B)", and by striking out "632(b)" and inserting in lieu thereof "632(a) (2)".

[(l) Subsection (c) of section 624 is amended by striking out "of any war" after "veteran".

[(m) Section 627 is amended by striking out "1958" and inserting "1957".

[(n) Subsection (a) (1) of section 628 is amended by striking out "they" and inserting in lieu thereof "delay".

[(o) Section 641 is amended by striking out "of any war or of service after January 31, 1955".

[(p) Section 643 is amended by striking out "of any war" after "veteran".

[Sec. 303. (a) The table of chapters and parts at the beginning of title 38 United States Code, and the table of chapters at the beginning of part II of such title are each amended by inserting in the title of chapter 17 "NURSING HOME," after "HOSPITAL".

[(b) The table of sections at the beginning of chapter 17 of such title is amended by—

[(1) inserting in the title of subchapter II a comma and "NURSING HOME," after "HOSPITAL";

[(2) inserting in the title of section 610 a comma and "nursing home" after "hospital";

[(3) inserting in the title of subchapter III "AND NURSING HOME" after "HOSPITAL"; and

[(4) striking out "Hospitalization" and inserting in lieu thereof "Care" in the title of section 611.

[Sec. 304. Chapter 23 of title 38, United States Code, is amended by inserting in subsection (a) of section 903 a comma and "nursing home," after "hospital", and by striking out "611" and inserting in lieu thereof "611(a)" in such subsection.

[Sec. 305. Subchapter I of chapter 73 of title 38, United States Code, is amended as follows:

[(a) (1) Subsection (a) of section 4101 is amended to read as follows: "The primary function of the Department of Medicine and Surgery shall be to provide a complete medical and hospital service, as provided in this title and in regulations prescribed by the Administrator pursuant thereto, for the medical care and treatment of veterans.";

[(2) Subsection (b) of section 4101 is amended by striking out "to provide a complete medical and hospital service for the medical care and treatment of veterans"; and

[(3) Section 4101 is further amended by redesignating subsection (c) as subsection (d) and inserting the following new subsection (c):

[(c) (1) In order to carry out more effectively the primary function of the Department of Medicine and Surgery and in order to contribute to the Nation's knowledge about disease and disability, the Administrator shall, in connection with the provision of medical care and treatment to veterans, carry out a program of medical research (including biomedical, prosthetic, and health care services research, and stressing research into spiral cord injuries and diseases and other disabilities that lead to paralysis of the lower extremities), acting in cooperation with the entities described in subsection (b) of this section.

[(2) Prosthetic research shall include research and testing in the field of prosthetic, orthotic, and orthopedic appliances and sensory devices. In order that the unique investigative material and research data in the possession of the Government may result in the improvement of such appliances and devices for all disabled persons, the Administrator, through the Chief Medical Director, shall make the results of such research available to any person, and shall consult and cooperate with the Secretary of Health, Education, and Welfare and the Commissioner of the Rehabilitation Services Administration, Department of Health, Education, and Welfare, in connection with programs carried out under section 3(b) of the Rehabilitation Act of 1973 (Public Law 93-112; 87 Stat. 357) (relating to the development and support, and the stimulation of the development and utilization, including production and distribution of new and existing devices, of innovative methods of applying advanced medical technology, scientific achievement, and psychological and social knowledge to solve rehabilitation problems), section 202(b)(2) of such Act (relating to the establishment and support of Rehabilitation Engineering Research Centers), and section 405 of such Act (relating to the secretarial responsibilities for planning, analysis, promoting utilization of scientific advances, and information clearing house activities).

[(3) (A) With the approval of the Administrator, any contract for research authorized by this section, the performance of which involves a risk of an unusually hazardous nature, may provide that the United States will indemnify the contractor against either or both of the following, but only to the extent that they arise out of the direct performance of the contract and to the extent not covered by the financial protection required under subparagraph (E) of this paragraph—

[(i) liability (including reasonable expenses of litigation or settlement) to third persons, except liability under State or Federal workers' injury

compensation laws to employees of the contractor employed at the site of and in connection with the contract for which indemnification is granted, for death, bodily injury, or loss of or damage to property, from a risk that the contract defines as unusually hazardous.

["(ii) loss of or damage to property of the contractor from a risk that the contract defines as unusually hazardous.

["(B) A contract that provides for indemnification in accordance with subparagraph (A) of this paragraph must also provide for—

["(i) notice to the United States of any claim or suit against the contractor for death, bodily injury, or loss of or damage to property; and

["(ii) control of or assistance in the defense by the United States, at its election, of any such suit or claim for which indemnification is provided hereunder.

["(C) No payment may be made under subparagraph (A) of this paragraph unless the Administrator, or the Administrator's designee, certifies that the amount is just and reasonable.

["(D) Upon approval by the Administrator, payments under subparagraph (A) of this paragraph may be made from—

["(i) funds obligated for the performance of the contract concerned;

["(ii) funds available for research or development, or both, and not otherwise obligated; or

["(iii) funds appropriated for those payments.

["(E) Each contractor which is a party to an indemnification agreement under subparagraph (A) of this paragraph shall have and maintain financial protection of such type and in such amounts as the Administrator shall require to cover liability to third persons and loss of or damage to the contractor's property. The amount of financial protection required shall be the maximum amount of insurance available from private sources, except that the Administrator may establish a lesser amount, taking into consideration the cost and terms of private insurance. Such financial protection may include private insurance, private contractual indemnities, self-insurance, other proof of financial responsibility, or a combination of such measures.

["(F) In administering the provisions of this paragraph the Administrator may use the facilities and services of private insurance organizations, and may contract to pay a reasonable compensation therefor. Any contract made under the provisions of this paragraph may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5), upon showing by the Administrator that advertising is not reasonably practicable, and advance payments may be made.

["(G) The authority to indemnify contractors under this paragraph does not create any rights in third persons which would not otherwise exist by law.

["(H) As used in this section, the term 'contractor' includes subcontractors of any tier under a contract in which an indemnification provision pursuant to subparagraph (A) of this paragraph is contained."

["(b) Chapter 39 of title 38, United States Code, is amended by—

["(1) striking out in the table of sections

["1904. Research and development; coordination with other Federal programs."

["and inserting in lieu thereof:

["1904. Research and development.";

["(2) amending the title of section 1904 to read as follows:

["§ 1904. Research and development";

["and

["(3) amending subsection (a) of section 1904 by striking out "prosthetic and orthopedic appliance research under section 216 and medical research" and inserting in lieu thereof "medical and prosthetic research".

["(c) Chapter 3 to title 38, United States Code, is amended by—

["(1) striking out section 216 in its entirety; and

["(2) amending the table of sections at the beginning thereof by striking out

["216. Research by the Administrator; indemnification of contractors.".

["(d) Section 4103 of such title is amended by—

["(1) inserting in Paragraphs (2) and (3) of subsection (a) "upon recommendation of the Chief Medical Director" after "Administrator";

[(2) striking out "recommendations" and inserting in lieu thereof "recommendation" in subsection (a) (4) ;

[(3) striking out "or reappointed" and inserting in lieu thereof a comma and "reappointed, or extended" in subsection (b) (3) ; and

[(4) inserting in subsection (c) before the period at the end of the second sentence a comma and "or for any period not exceeding two years."

[(e) Subsection (a) (5) of section 4105 of title 38, United States Code, is amended by inserting "hold the degree of doctor of optometry from a school of optometry approved by the Administrator and" before "be".

[(f) Subsection (b) of section 4108 is amended by striking out "pursuant to" after "agreement" and inserting in lieu thereof "as referred to in".

[(g) Subsection (b) of section 4114 is amended by amending paragraph (2) to read as follows :

["(2) For the purposes of this title, the term 'internship' shall include the equivalency of an internship as determined in accordance with regulations which the Administrator shall prescribe, and the term 'intern' shall mean a person serving an internship.".

[SEC. 306. Chapter 81 of title 38, United States Code, is amended as follows :

[(a) Subsection (a) (2) of section 5001 is amended by—

[(1) striking out "and exclusive" in subsection (a) (2), and striking out "tuberculosis" and inserting in lieu thereof "tuberculous" in such subsection ; and

[(2) striking out "and exclusive" in subsection (a) (3).

[(b) Subchapter III of such chapter is amended by striking out "war" each time it appears in subsection (a) of section 5031, section 5032, paragraph (1) of section 5034, paragraphs (4) of subsections (a) and (b) of section 5035, and section 5036.

[(c) Section 5053 is amended by—

[(1) striking out "paragraphs" and inserting in lieu thereof "clauses" in the first sentence of subsection (a) ; and

[(2) inserting in clauses (1) and (2) of subsection (a) and in subsection (c) "health care" after "Veterans' Administration" each place it appears.

[(d) Subsection (b) of section 5054 is amended by inserting "the" before "surrounding medical community" the second place it appears.

[(e) The second sentence of subsection (a) of section 5055 is amended by striking out "for Research and Education in Medicine" and inserting in lieu thereof "charged with administration of the Department of Medicine and Surgery medical research program".

[SEC. 307. Subchapter II of chapter 82 of title 38, United States Code, is amended by striking out in subsection (a) of section 5083 "subchapter IV of chapter 81 of".

[SEC. 308. Chapter 85 of title 38, United States Code, is amended as follows :

[(a) Subsection (b) of section 5202 is amended by inserting "or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title." after "(admitted as a veteran)" in the first sentence.

[(b) Subsection (a) of section 5220 is amended by inserting a comma and "or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title." after "(admitted as a veteran)".

[(c) Section 5221 is amended by inserting a comma and or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title." after "(admitted as such)".

[SEC. 309. (a) Subchapter I of chapter 73 of title 38, United States Code, is amended as follows :

[(1) Subsection (b) of section 4101, clause (1) of section 4104, subsection (b) of section 4105, subsection (f) of section 4106, subsection (f) of section 4107, and the language preceding clause (1) in subsection (a) and clause (6) (B) of section 4108, are each amended by striking out "physicians" and inserting in lieu thereof "physician".

[(2) Subsection (b) of section 4101 is further amended by striking out "dentists' assistants" and inserting in lieu thereof "expanded-duty dental auxiliaries".

[(3) Subsection (a) (8) of section 4105 is further amended by striking out "Physicians" and inserting in lieu thereof "Physician".

[(4) Section 4113 is amended by striking out "and nurses" and inserting in lieu thereof "nurses, physician assistants, and expanded-duty dental auxiliaries".

[(5) Section 4114 is amended by—

[(A) inserting in clauses (A) and (B) of subsection (a) (1) "physician assistants, expanded-duty dental auxiliaries," after "nurses," ;

[(B) striking out "and nurses" and inserting in lieu thereof "nurses, physician assistants, and expanded-duty dental auxiliaries" in the first sentence of subsection (a) (3) (A) ;

[(C) striking out "nurses and interns, and" and inserting in lieu thereof "nurses, physician assistants, expanded-duty dental auxiliaries, and interns," in subsection (a) (3) (B) ; and

[(D) striking out "dentist's assistant" and inserting in lieu thereof "expanded-duty dental auxiliary" in subsection (e).

[(6) Subsection (a) of section 4116 is amended by striking out "physicians' assistant, dentists' assistant" each time those words appear and inserting in lieu thereof "physician assistant, expanded-duty dental auxiliary".

[(7) Section 4117 is amended by striking out "dentists' assistants" and inserting in lieu thereof "expanded-duty dental auxiliaries".

[(b) Subchapter I of chapter 73 of title 38, United States Code, is further amended as follows :

[(1) Section 4106 is amended by—

[(A) inserting in subsection (c) "rate of basic" after "minimum"; and

[(B) striking out "level and salary" and "and salary" and inserting in lieu thereof "and annual rate of basic pay" each place such terms appear in subsection (e).

[(2) Section 4107 is amended by—

[(A) striking out "per annum full-pay scale or ranges" and inserting in lieu thereof "annual rates or ranges of rates of basic pay" in subsection (a) ;

[(B) striking out "per annum full-pay ranges" and inserting in lieu thereof "annual ranges of rates of basic pay" in subsection (b) (1) ;

[(C) inserting in the first sentence of subsection (c) "facility" after "domiciliary" each place it appears; and

[(D) amending subsection (e) by—

[(i) striking out "basic compensation" and inserting in lieu thereof "rate of basic pay" in paragraph (1) ;

[(ii) striking out "basic hourly rate" or "basic hourly rate of pay" each time such words appear and inserting in lieu thereof "hourly rate of basic pay" in paragraphs (2), (3), (5), (6), and (7) ;

[(iii) striking out "compensation" each time it appears and inserting in lieu thereof "pay" in paragraphs (1), (2), (3), (6), and (9) ;

[(iv) amending the first sentence of paragraph (4) to read as follows: "A nurse performing service on a holiday designated by Federal statute or Executive order shall receive for each hour of such service the nurse's hourly rate of basic pay, plus additional pay at a rate equal to such hourly rate of basic pay, for that holiday service, including overtime service."; and

[(v) striking out "compensated" and inserting in lieu thereof "paid" in paragraph (8).

[(3) Subsection (a) of section 4112 is amended by striking out "compensation" and inserting in lieu thereof "pay" in the last sentence of such subsection.

[(c) Chapter 73 of title 38, United States Code, is further amended as follows :

[(1) Section 4103 is amended by—

[(A) striking out "individuals" and inserting in lieu thereof "persons" in subsection (a) (4) ;

[(B) striking out "and employees" in subsection (a) (8) ; and

[(C) striking out "An individual" and inserting in lieu thereof "A person" in the second sentence of subsection (c).

[(2) Subsection (a) of section 4105 is amended by striking out "employees" and inserting in lieu thereof "personnel" in clause (7).

[(3) Section 4107 is amended by—

[(A) striking out "individual" and inserting in lieu thereof "person" in subsection (c) ;

[(B) striking out "employee's" and inserting in lieu thereof "nurse's"; and striking out "work" and inserting in lieu thereof "service" in paragraph (2) of subsection (e) ; and

[(C) striking out "duty" and inserting in lieu thereof "service" in paragraph (7) of subsection (e).

[(4) Subsection (a) of section 4108 is amended by striking out "individual" and inserting in lieu thereof "person" in clause (1).

[(5) Section 4113 is amended by—

[(A) striking out "of employees" and inserting in lieu thereof a comma and "of persons"; and

[(B) striking out "paragraph (1) of section 4104" and inserting in lieu thereof "section 4104 (1)."]

[(6) Subsection (d) (2) of section 4114 is amended by striking out "individual" and inserting in lieu thereof "person".

[(7) Subsection (b) of section 4122 is amended by striking out "individuals" each time it appears and inserting in lieu thereof "persons".

[SEC. 310. (a) Chapter 17 of title 38, United States Code, is amended as follows:

[(1) Section 610 is amended by—

[(A) striking out "he" and inserting in lieu thereof "the Administrator" in the first sentence of subsection (a);

[(B) striking out "he" and inserting in lieu thereof "such veteran" in subsections (a) (1) (B), (b) (2), and (c); and

[(C) striking out "he" and inserting in lieu thereof "such person" in subsection (b) (1).

[(2) Section 611 is amended by—

[(A) striking out "him" and inserting in lieu thereof "the Administrator" in subsection (a); and

[(B) striking out "he" and "him" and inserting in lieu thereof at each place "the Administrator" in subsection (b);

[(3) Section 612 is amended by—

[(A) striking out "he" and inserting in lieu thereof "the Administrator" in the first sentence of subsection (a);

[(B) striking out "him" and "he" and inserting in lieu thereof at each place "the Administrator" in subsection (d);

[(C) striking out "he" and inserting in lieu thereof "the Administrator" in subsection (g); and

[(D) striking out "his" and inserting in lieu thereof "such veteran's" at each place it appears in the second sentence of subsection (h).

[(4) Section 613 is amended by—

[(A) striking out "he" and inserting in lieu thereof "the Secretary" in subsection (b) (1); and

[(B) striking out "he" each place it appears and inserting in lieu thereof "the Administrator" in subsection (b) (2).

[(5) Section 614 is amended by—

[(A) striking out "his" and inserting in lieu thereof "such veteran's" in subsection (a); and

[(B) striking out "he" in subsection (b).

[(6) Section 619 is amended by striking out "him" and inserting in lieu thereof "such veteran".

[(7) Subsection (b) of section 620 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(8) Paragraphs (1) and (3) of section 621 are amended by striking out "he" each place it appears and inserting in lieu thereof "the Administrator".

[(9) Subsection (b) of section 622 is amended by striking out "his" and inserting in lieu thereof "such veterans".

[(10) Section 623 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(11) Subsection (c) of section 624 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(12) Section 626 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(13) Subsection (a) of section 628 is amended by—

[(A) striking out "he" and inserting in lieu thereof "the Administrator" in the first sentence of such subsection; and

[(B) striking out "his" and inserting in lieu thereof "such veteran's" in paragraph (2) (d) (ii) of such subsection.

[(14) Subsection (d) of section 632 is amended by striking out in the second sentence "him" and inserting in lieu thereof "the Administrator".

[(15) Section 633 is amended by striking out "he" and "his" and inserting in lieu thereof "the President" and "the President's", respectively.

[(16) Subsection (a) of section 642 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(b) Chapter 73 of title 38, United States Code, is amended as follows:

[(1) Section 4101 is amended by—

[(A) striking out "servicemen" and inserting in lieu thereof "members of the uniformed services" in subsection (b); and

- [(B) striking out "his" and "he" and inserting in lieu thereof "the Administrator's" and "the Administrator", respectively.
- [(2) Section 4103 is amended by—
- [(A) striking out in subsection (a) (1) the period at the end of the first sentence and "He" in the second sentence and inserting in lieu thereof a comma at each place ;
- [(B) striking out in subsection (a) (2) the period at the end of the first sentence and "He" in the second sentence and inserting in lieu thereof a comma at each place ;
- [(C) striking out in subsection (a) (3) the period at the end of the first sentence and "He" in the second sentence and inserting in lieu thereof a comma at each place ; and
- [(D) striking out in the third sentence of subsection (c) "his" and "he" and inserting in lieu thereof "such person's" and "such person", respectively.
- [(3) Section 4104 is amended by striking out "he" and inserting in lieu thereof "the Administrator".
- [(4) Subsection (b) of section 4105 is amended by striking out "he" and inserting in lieu thereof "such person".
- [(5) Subsection (b) of section 4106 is amended by striking out "him" and "he" and inserting "such person" at each place.
- [(6) Section 4107 is amended by—
- [(A) striking out "he" each place it appears and inserting in lieu thereof "such person" in subsection (b) (2) ; and
- [(B) striking out "he" and "his" and inserting in lieu thereof "such person" and "such person's", respectively, in subsection (c).
- [(7) Subsection (a) of section 4108 is amended by—
- [(A) striking out "his" and inserting in lieu thereof "such person's" in clause (2) ;
- [(B) striking out "him" and inserting in lieu thereof "such person" in clause (3) ;
- [(C) striking out "him" and "his" and inserting in lieu thereof "such person" and "such person's", respectively, in clause (4) ;
- [(D) striking out "his" each place it appears and "him" and inserting in lieu thereof "such person's" and "such person", respectively, in clause (5) ; and
- [(E) striking out "his" each place it appears and inserting in lieu thereof "such person's" in clause (6).
- [(8) Section 4110 is amended by—
- [(A) striking out "his" and inserting in lieu thereof "such person's" in subsection (c) ;
- [(B) striking out "He" and "he" and inserting in lieu thereof "The Administrator", and "the Administrator", respectively, in the third sentence of subsection (d) ; and
- [(C) striking out "he" and "him" and inserting in lieu thereof "the Administrator" at each place it appears in the first sentence of subsection (e).
- [(9) Subsection (b) of section 4112 is amended by striking out "he" and inserting in lieu thereof "the Administrator".
- [(10) Section 4114 is amended by—
- [(A) striking out in the third sentence "he" and inserting in lieu thereof "such recipient" each place it appears in subsection (b) (3) ;
- [(B) striking out "he" and "his" and inserting in lieu thereof "such person" and "such person's", respectively, each place such word appears in the last sentence of subsection (b) (3) ;
- [(C) striking out "he" and inserting in lieu thereof "the person" in subsection (d) (1) ; and
- [(D) striking out "his" and "he" and inserting in lieu thereof "such person" and "the person", respectively, in subsection (d) (2).
- [(11) Section 4116 is amended by—
- [(A) striking out "his" and inserting in lieu thereof "such person's" each place it appears in subsection (a) ;
- [(B) striking out "his" and "him" and inserting in lieu thereof "such person's" and "such person," respectively, each place such word appears in subsection (b) ;
- [(C) striking out "his" and inserting in lieu thereof "such person's" each place it appears in subsection (c) ; and

[(D) striking out "he" and "his" and inserting in lieu thereof "the Administrator" and "such persons", respectively, each place such word appears in subsection (e).

[(12) Subsection (a) of section 4121 is amended by striking out "his" and "he" and inserting in lieu thereof "the Administrator's" and "the Administrator", respectively, each place such word appears.

[(13) Section 4122 is amended by—

[(A) striking out "he" and inserting in lieu thereof "the Chief Medical Director" in subsection (b) ; and

[(B) striking out "he" and inserting in lieu thereof "the Chief Medical Director" in subsection (c).

[(c) Chapter 75 of title 38, United States Code, is amended by striking out "he" and inserting in lieu thereof "the Administrator" each place it appears in clauses (3), (9), (10), and (11) of section 4202.

[(d) Chapter 81 of title 38, United States Code, is amended as follows:

[(1) Subsection (b) of section 5001 is amended by striking out "him" and "his" and inserting in lieu thereof "the Administrator" and "the Chief Medical Director's", respectively.

[(2) Section 5002 is amended by—

[(A) striking out "he" and inserting in lieu thereof "the President" each place it appears ; and

[(B) striking out "his opinion" and inserting in lieu thereof "the opinion of the President such is".

[(3) Paragraphs (2) and (3) of subsection (b) of section 5004 are amended by striking out "he" and inserting in lieu thereof "the Administrator" each place it appears.

[(4) Section 5005 is amended by striking out "He" and inserting in lieu thereof "The President" in the second sentence.

[(5) Section 5007 is amended by striking out "his" and inserting in lieu thereof "the Administrator's".

[(6) Subsection (c) of section 5011 is amended by striking out "him" and inserting in lieu thereof "the Administrator".

[(7) Section 5012 is amended by—

[(A) striking out "his" and inserting in lieu thereof "the Administrator's" each place it appears in subsection (a) ;

[(B) striking out "he" and inserting in lieu thereof "the Administrator" in section (b) ; and

[(C) striking out "him" and inserting in lieu thereof "the Administrator" in subsection (c).

[(8) Section 5013 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(9) Section 5014 is amended by—

[(A) striking out "he" and inserting in lieu thereof "the Administrator" each place it appears ; and

[(B) striking out "his" and inserting in lieu thereof "the Administrator's".

[(10) Subsection (b) of section 5035 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(11) Subsection (a) of section 5053 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(12) Subsection (b) of section 5054 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(13) Subsection (a) of section 5055 is amended by striking out "him" and inserting in lieu thereof "the Administrator".

[(e) Chapter 82 of title 38, United States Code, is amended as follows:

[(1) Subsection (e) of section 5070 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(2) Section 5071 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[(3) Section 5073 is amended by—

[(A) striking out "he" and inserting in lieu thereof "the Administrator" each place it appears in subsection (b) (1) ; and

[(B) striking out "he" and inserting in lieu thereof "the Administrator" each place it appears in subsection (c).

[(4) Subsection (b) of section 5083 is amended by striking out "his" and inserting in lieu thereof "the Administrator's" each place it appears in the first sentence and in paragraph (4) of such subsection.

[(5) Subsection (b) of section 5093 is amended by striking out "his" and inserting in lieu thereof "the Administrator's" each place it appears in the first sentence and in paragraph (4) of such subsection.

[(6) Section 5096 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

[SEC. 311. Except as otherwise provided in this Act, the amendments made by this Act to title 38, United States Code, shall become effective thirty days after the first day of the first calendar month following the date of enactment of the Act.]

and insert in lieu thereof the following:

That this Act may be cited as the "Veterans Omnibus Health Care Act of 1976".

TITLE I—GENERAL VETERANS HEALTH CARE AND DEPARTMENT OF MEDICINE AND SURGERY AMENDMENTS

SEC. 101. Section 111 of title 38, United States Code, is amended by—

(1) inserting in subsection (a) "pursuant to the provisions of this section" after "President"; and

(2) inserting at the end of such section the following new subsection:

"(e) (1) In carrying out the purposes of this section, the Administrator, in consultation with the Administrator of General Services, the Secretary of Transportation, the Comptroller General of the United States, and representatives of organizations of veterans, shall conduct periodic investigations of the actual cost of travel (including lodging and subsistence) to beneficiaries while traveling to or from a Veterans' Administration facility or other place pursuant to the provisions of this section, and the estimated cost of alternative modes of travel, including public transportation and the operation of privately owned vehicles. The Administrator shall conduct such investigations immediately following any alteration in the rates described in paragraph (3) (C) of this subsection, and, in any event, immediately following the enactment of this subsection and not less often than annually thereafter, and, based thereon, shall determine rates of allowances or reimbursement to be paid under this section.

"(2) In no event shall the payment be provided under this section—

"(A) unless the person claiming reimbursement has been determined, based on an annual declaration and certification by such person, to be unable to defray the expenses of such travel (except with respect to a veteran receiving benefits for or in connection with a service-connected disability under this title);

"(B) to reimburse for the cost of travel by privately owned vehicle in any amount in excess of the cost of such travel by public transportation unless (i) public transportation is not reasonably accessible or would be medically inadvisable, or (ii) the cost of such travel is not greater than the cost of public transportation; and

"(C) in excess of the actual expense incurred by such person as certified in writing by such person.

"(3) In conducting investigations and determining rates under this section, the Administrator shall review and analyze, among other factors, the following factors:

"(A) (i) Depreciation of original vehicle costs;

"(ii) gasoline and oil costs;

"(iii) maintenance, accessories, parts, and tires costs;

"(iv) insurance costs; and

"(v) State and Federal taxes.

"(B) The availability of and time required for public transportation.

"(C) The per diem rates, mileage allowances, and expenses of travel authorized under sections 5702 and 5704 of title 5 for employees of the United States.

"(4) Before determining rates under this section, not later than sixty days after the date of the enactment of this subsection, and thereafter not later than sixty days after any alteration in the rates described in paragraph (3) (C) of this subsection, the Administrator shall publish in the Federal Register and submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing the rates the Administrator proposes to establish or continue with a full justification therefor in terms of each of the

limitations and factors set forth in this section. The justification provided under this paragraph shall specify the extent to which and the full reasons why the proposed rates would differ from the rates in effect under sections 5702 and 5704 of title 5 for employees of the United States traveling on official business.”.

SEC. 102. Section 601 of title 38, United States Code, is amended by—

(1) amending paragraph (5) by striking out in clause (B) all after “training” and inserting in lieu thereof “for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of a veteran or dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title; and”;

(2) amending paragraph (6) to read as follows:

“(6) The term ‘medical services’ includes, in addition to medical examination, treatment, and rehabilitative services—

“(A) (i) surgical services, dental services and appliances as authorized in section 612 (b), (c), (d), and (e) of this title, optometric and podiatric services, and (except under the conditions described in section 612 (f) (1) (A) of this title), wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services (including the maintenance of patient drug profiles, patient drug monitoring, and drug utilization education) as the Administrator determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

“(B) such—

“(i) consultation, professional counseling, and training, and

“(ii) mental health services in connection with the treatment of (I) the service-connected disability of a veteran pursuant to section 612 (a), or the readjustment problem of a veteran pursuant to section 612A, of this title, and (II) in the discretion of the Administrator, other disabilities related to the mental health of a veteran pursuant to section 612 (f) (1) (B) of this title where such services were initiated during the veteran’s hospitalization,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, necessary expenses of travel and subsistence of such family member or individual in the case of a veteran who is receiving care for a service-connected disability or in the case of a dependent or survivor of a veteran receiving care under the last sentence of section 613 (b) of this title). For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 613 (b) of this title shall be eligible for the same medical services as a veteran.”;

(3) amending paragraph (7) to read as follows:

“(7) The term ‘domiciliary care’ includes necessary medical services and travel and incidental expenses pursuant to the provisions of section 111 of this title.”; and

(4) inserting at the end of such section the following new paragraph (8):

“(8) The term ‘rehabilitative services’ means such professional, counseling, and guidance services and treatment programs (other than those types of vocational rehabilitation services provided under chapter 31 of this title) as are necessary to restore the physical, mental, and psychological functioning of an ill or disabled person.”.

SEC. 103. (a) Subchapter I of chapter 17 of title 38, United States Code, is amended by inserting after section 602 the following new section:

“§ 603. Presumption relating to internment as prisoner of war

“For the purposes of this chapter, the disability of any veteran who was for more than six months a prisoner of war, as provided in section 312 (c) of this title, shall be deemed to have been incurred in the active military, naval, or air service if such disability, on the basis of sound medical judgment, could be attributable to or aggravated by the internment of such veteran as a prisoner of war unless the Administrator finds, on the basis of clear and convincing evidence, that the disability was not attributable to or aggravated by such internment.”.

(b) The table of sections at the beginning of chapter 17 of title 38, United States Code, is amended by inserting

"603. Presumption relating to internment as prisoner of war."

below

"602. Presumption relating to psychosis."

SEC. 104. (a) Section 612 of title 38, United States Code, is amended by—

(1) inserting after the first sentence of subsection (a) the following new sentence: "The Administrator may also furnish to any such veteran such home health services as the Administrator finds to be necessary or appropriate for the effective and economical treatment of such disability (including only such improvements and structural alterations (or reimbursement for an appropriate portion of the cost thereof) as are necessary to assure the continuation of treatment for such disability or to provide access to the home or to essential lavatory and sanitary facilities, and the cost of which does not exceed the cost of the average period of hospitalization under section 610 of this title, as determined annually by the Administrator).";

(2) inserting in clause (4) of subsection (b) "(A)" after "disability" and inserting before the semicolon a comma and "or (B) for which such veteran is receiving treatment (not including routine dental care)";

(3) striking out "or" at the end of such clause (4); redesignating clause (5) as clause (6); and inserting after clause (4) in subsection (b) the following new clause (5):

"(5) which is a non-service-connected condition or disability of a veteran for which treatment was begun while such veteran was receiving hospital care under this chapter and such services and treatment are reasonably necessary to complete such treatment; or";

(4) striking out "may also furnish" in subsection (f) and inserting in lieu thereof a comma and "within the limits of Veterans' Administration facilities, may furnish";

(5) inserting in clause (1)(A) of subsection (f) "(to the extent that facilities are available)" after "or" the first place it appears;

(6) inserting before the semicolon at the end of clause (1)(B) of subsection (f) "(for a period not in excess of twelve months after discharge from in-hospital treatment, except where the Administrator finds (i) that a longer period is required by virtue of the disability being treated, and (ii) with respect to private facilities for which the Administrator contracts, that alternative Federal reimbursement is not reasonably available to defray substantially the costs of such treatment)";

(7) striking out "80" and inserting in lieu thereof "50" in clause (2) of subsection (f);

(8) inserting at the end of subsection (f) the following new sentence: "The Administrator may also furnish to any such veteran such home health services as the Administrator determines to be necessary or appropriate for the effective and economical treatment of a disability of a veteran (including only such improvements and structural alterations (or reimbursement for an appropriate portion of the cost thereof) as are of a minor nature and are necessary to assure the continuation of treatment or provide access to the home or to essential lavatory and sanitary facilities."); and

(9) inserting at the end thereof the following new subsection:

"(i) Not later than ninety days after the date of enactment of this subsection, the Administrator shall prescribe regulations to ensure that special priority in furnishing medical services under this section and any other outpatient care with funds appropriated for the medical care of veterans shall be accorded in the following order, except in the case of medical emergencies which pose a serious threat to life or health:

"(1) To any veteran for a service-connected disability.

"(2) To any veteran described in subsection (f)(2) of this section.

"(3) To any veteran with a disability rated as service-connected or eligible, by reason of section 612A of this title, for outpatient mental health services under section 612(f)(1)(B) of this title.

"(4) To any veteran being furnished medical services under subsection (g) of this section."

(b) Not later than one year after the date of enactment of this section, and annually thereafter, the Administrator shall report to the Congress on the results of the regulations prescribed to carry out the amendment made by subsection (a)(9) of this section.

SEC. 105. (a) Subchapter II of chapter 17 of title 38, United States Code, is amended by inserting after section 612 the following new section:

"§ 612A. Eligibility for readjustment professional counseling

"(a) The Administrator may furnish initial readjustment professional counseling (including a general mental and psychological assessment in connection therewith), and travel and incidental expenses pursuant to the provisions of section 111 of this title for any veteran who served after August 4, 1964, and who requests assistance with readjustment problems within a period not to exceed four years after the date of such veteran's discharge or release from service, or two years after the date of the enactment of this section, whichever is later.

"(b) If, on the basis of initial counseling furnished under subsection (a) of this section, it is determined that the provision of mental health services is necessary to facilitate the successful readjustment of the veteran, such veteran shall be furnished such services on an outpatient basis as a part of medical services provided under the conditions specified in clause (1)(B) of section 612(f) of this title. For the purposes of furnishing such services, the counseling furnished under subsection (a) of this section shall be deemed to have been furnished as a part of hospital care. Any hospital care and other medical services deemed necessary as a result of such initial counseling shall be furnished in accordance with the eligibility criteria otherwise set forth in this chapter (including section 611(b) thereof), and where a particular veteran is not eligible for necessary care or services, the Administrator shall provide referral services to assure, to the maximum extent practicable, that such care or services are provided from sources outside the Veterans' Administration.

"(c) The Chief Medical Director shall provide for such training of professional, paraprofessional, and lay personnel as is necessary to carry out this section effectively, and shall make maximum utilization of the services of paraprofessionals, voluntary (without compensation) workers, and veteran students (under section 1685 of this title) in initial intake and screening activities.

"(d) The Administrator, in cooperation with the Secretary of Defense, shall take appropriate action, as provided in section 241 of this title, to ensure that all veterans eligible for assistance under this section are advised of their eligibility for such assistance and are encouraged to take full advantage thereof."

(b) The table of sections at the beginning of such chapter is amended by inserting

"612A. Eligibility for readjustment professional counseling."
below

"612. Eligibility for medical treatment."

Sec. 106. Subsection (a) of section 613 of title 38, United States Code, is amended by amending clause (2) to read as follows:

"(2) the widow or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability,".

Sec. 107. (a) Section 618 of title 38, United States Code, is amended by—

(1) striking out "The" in the first sentence and inserting in lieu thereof

"(a) In providing rehabilitative services under this chapter, the";

(2) striking out "hospitals and domiciliaries" and inserting in lieu thereof "health care facilities"; and

(3) inserting below subsection (a) (as redesignated by clause (1) of this subsection) the following new subsections:

"(b) (1) In furnishing rehabilitative services under this chapter, the Administrator, upon the recommendation of the Chief Medical Director, may enter into arrangements with private industry or other sources outside the Veterans' Administration to provide for therapeutic work for remuneration for patients and members in Veterans' Administration health care facilities.

"(2) Notwithstanding any other provision of law, the Administrator may also furnish rehabilitative services under this subsection through arrangements with nonprofit entities to provide for such therapeutic work for such patients. The Administrator shall establish appropriate fiscal, accounting, management, record-keeping, and reporting requirements with respect to the activities of any such nonprofit entity in connection with such arrangements.

"(c) (1) There is hereby established in the Treasury of the United States a revolving fund known as the Veterans' Administration Special Therapeutic and

Rehabilitation Activities Fund (hereinafter called the 'fund') for the purpose of carrying out the provisions of subsection (b) of this section. Such amounts of the fund as the Administrator may determine to be necessary to establish and maintain operating accounts for the various rehabilitative services activities may be deposited in checking accounts in other depositories selected or established by the Administrator.

"(2) All funds received by the Veterans' Administration under arrangements made under subsection (b) of this section, or by nonprofit entities described in paragraph (2) of such subsection, shall be deposited in or credited to the fund, and the Administrator shall pay out of the fund moneys to participants at rates not less than the wage rates specified in the Fair Labor Standards Act (29 U.S.C. 201 et seq.) and regulations prescribed thereunder for work of similar character.

"(3) In connection with the establishment and operation of the fund, the Administrator shall transfer to the fund not to exceed \$2,000,000 from funds appropriated for the medical care of veterans. Any balance in the fund at the end of each fiscal year in excess of the estimated requirements for the ensuing two fiscal years shall be credited to that medical care appropriation.

"(4) The Chief Medical Director shall prepare, for inclusion in the annual report submitted to Congress under section 214 of this title, a description of the scope and achievements of activities carried out under this section (including pertinent data regarding productivity and wage rates) during the prior twelve months and an estimate of the needs of the program of therapeutic and rehabilitation activities to be carried out under this section for the ensuing fiscal year.

"(d) In providing rehabilitative services under this chapter, the Administrator shall take appropriate action to make it possible for the patient to take maximum advantage of any benefits to which such patient is entitled under chapter 31, 34, or 35 of this title, and, if the patient is still receiving treatment of a prolonged nature under this chapter, the provision of rehabilitative services under this chapter shall be continued during, and coordinated with, the pursuit of education and training under such chapter 31, 34, or 35.

"(e) The Administrator shall prescribe regulations to ensure that the priorities set forth in section 612(i) of this title shall be applied, insofar as practicable, to participation in therapeutic and rehabilitation activities carried out under this section."

(b) (1) The Administrator is authorized to settle claims made by the Veterans' Administration against any private nonprofit corporation organized under the laws of any State, for the use of Veterans' Administration facilities and personnel in work projects as a part of a therapeutic or rehabilitation program for patients and members in Veterans' Administration health care facilities, and to execute a binding release of all claims by the United States against any such corporation, in such amounts, and upon such terms and conditions as the Administrator deems appropriate.

(2) For the purposes of this section, notwithstanding section 484 of title 31, or any other provision of law, the Administrator may utilize any funds received under any settlement made pursuant to subsection (a) for any purpose agreed upon by the Administrator and such corporation.

SEC. 108. Section 620 of title 38, United States Code, is amended by—

(1) inserting in subsection (a) "and except as provided in subsection (e)" after "subsection (b)";

(2) striking out "40 per centum" and inserting in lieu thereof "45 per centum" in clause (ii) of subsection (a);

(3) inserting before the period at the end of clause (ii) of subsection (a) a comma and "or not to exceed 50 per centum of such cost where determined necessary by the Administrator, upon recommendation of the Chief Medical Director, to provide adequate care";

(4) amending the first sentence of subsection (d) by—

(A) inserting "(1)" after "care" the first time it appears in such sentence; and

(B) inserting after "disability" a comma and "or (2) in the discretion of the Administrator in accordance with the priorities described in section 612(i), for a non-service-connected disability,"; and

(5) inserting at the end thereof the following new subsection:

"(e) For the purposes of this section, the term 'nursing home care' includes intermediate care, as determined by the Administrator in accordance with regulations which the Administrator shall prescribe. The cost of intermediate care for purposes of payment by the United States pursuant to subsection (a) (ii) of this section shall be determined by the Administrator except that the rate of

reimbursement shall be commensurately less than that provided for nursing home care (as defined in section 101(28) of this title).".

SEC. 109. (a) Subchapter V of chapter 17 of title 38, United States Code, is amended by—

(1) striking out the semicolon and all thereafter in section 641 and inserting in lieu thereof a period and the following new sentences: "No payment shall be made with respect to any veteran under this section in excess of one-half of the cost of the veteran's care in such State home. For the purposes of this section and consistent with the limitation in the preceding sentence, the Administrator shall apply the definition of nursing home care set forth in section 5031(5) of this title with respect to determining the rate of per diem payable for any veteran receiving care in a State home in any State described in such section."; and

(2) amending section 642 by inserting at the end of subsection (a) the following new sentence: "No payment or grant may be made to any home under this subchapter unless such home is determined by the Administrator to meet such standards as the Administrator shall prescribe, which standards with respect to nursing home care shall be no less stringent than those prescribed pursuant to section 620(b) of this title.".

(b) Subchapter III of chapter 81 of title 38, United States Code, is amended by—

(1) amending section 5031 by—

(A) redesignating paragraphs (a), (b), (c), and (d) as (1), (2), (3), and (4) respectively, and inserting after "buildings" the second place it appears in paragraph (3) (as so redesignated) "(including buildings not presently used for providing nursing home care)"; and

(B) inserting at the end thereof the following new paragraph:

"(5) The term 'nursing home care' shall be deemed to include domiciliary care provided in any State in which no Veterans' Administration hospital or domiciliary facility is located.".

(2) amending section 5034 by—

(A) striking out "subchapter" the first place it appears and inserting in lieu thereof "section or any amendment to it with respect to such amendment"; and

(B) inserting at the end thereof the following new clause:

"(3) General standards for the furnishing of nursing home care in facilities which are constructed with assistance received under this subchapter, which standards shall be no less stringent than those standards prescribed by the Administrator pursuant to section 620(b) of this title, except that facilities constructed with assistance received under this subchapter pursuant to the definition in section 5031(5) of this title shall meet such standards as the Administrator shall prescribe. The Administrator may inspect any State facility constructed with assistance received under this subchapter at such times as the Administrator deems necessary to ensure that such facility meets such standards.".

(3) Section 5035 is amended by—

(A) inserting at the end of clause (4) of subsection (a) "subject to the provisions of subsection (c) (1) of this section,"; and

(B) redesignating subsection (c) as paragraph (2) and inserting above such redesignated paragraph the following:

"(c) (1) The Administrator shall waive requirements set forth in subsection (a) (4) of this section in the case of an application from any State described in section 5031(5) of this title to the extent that such State provides reasonable assurance that the portion of the facility constructed with assistance received under this subchapter will be used principally for veterans and that not more than such proportion as the Administrator shall deem reasonable (not less than 50 per centum) of the bed occupancy at any one time will consist of patients who are not receiving care as veterans.".

SEC. 110. (a) Chapter 17 of title 38, United States Code, is amended by inserting at the end thereof the following new subchapter:

"Subchapter VII—Preventive Health Care Program

"§ 660. Purpose

"The purpose of this subchapter is to provide for a preventive health care program under which the Administrator (1) shall attempt to ensure the best possible health care for veterans with service-connected disabilities by furnishing them

feasible and appropriate preventive health care services, and (2) may, in connection therewith, carry out a pilot program (including research) on a geographical or other basis to determine the cost-effectiveness and medical advantages of furnishing preventive health care services to veterans with service-connected disabilities.

"§ 661. Definition

"For the purposes of this subchapter, the term 'preventive health care services' may include, but is not limited to, periodic medical and dental examinations; patient health education (including nutrition education); maintenance of drug use profiles, patient drug monitoring, and drug utilization education; mental health preventive services (including family counseling); substance (including tobacco) abuse prevention measures; immunizations against infectious disease; prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature; genetic counseling concerning inheritance of genetically determined diseases; routine vision testing and eye care services; periodic re-examination of likely target population (high-risk groups) for selected diseases and for functional decline of sensory organs, together with attendant appropriate remedial intervention; and such other medical services as may be necessary for providing effective and economical preventive health care.

"§ 662. Preventive health care services; pilot program

"(a) (1) The Administrator, in accordance with regulations which the Administrator shall prescribe, may furnish, on an inpatient, outpatient, or ambulatory basis, nationally or geographically, such preventive health care services as the Administrator determines are feasible and appropriate to any veteran in connection with the treatment of a service-connected disability under this chapter and to any veteran described in section 612(f) (2) of this title.

"(2) In connection with preventive health care services furnished under paragraph (1) of this subsection, the Administrator, in accordance with regulations which the Administrator shall prescribe, may institute appropriate controls and carry out followup studies (including research) to demonstrate the medical advantages and cost-effectiveness of furnishing such preventive health care services.

"(b) (1) The Administrator shall provide for the planning, design, and conduct of a health maintenance pilot program to demonstrate the medical advantages and cost-effectiveness of furnishing, in accordance with the priorities specified in section 612(i) of this title, comprehensive preventive health care services to veterans with service-connected disabilities. Such pilot program shall be undertaken as a controlled scientifically valid study involving not to exceed 10,000 veterans (including control groups) and shall be initiated on October 1, 1977.

"(2) The Administrator may not furnish comprehensive preventive health care services under paragraph (1) of this subsection after the last day of the tenth fiscal year following the fiscal year in which the pilot program is initiated.

"(c) In carrying out the preventive health care program provided for in this subchapter, the Administrator shall emphasize the utilization of interdisciplinary health care teams composed, to the maximum extent feasible, of various professional and paraprofessional personnel, such as public health nurses, psychologists, optometrists, technicians, physician assistants, and expanded-function dental auxiliaries.

"(d) In order to assist the Secretary of Health, Education, and Welfare in carrying out national immunization programs pursuant to other provisions of law, the Administrator may authorize the administration of immunizations to eligible veterans in connection with the provisions of care for a disability under this chapter in any Veterans' Administration health care facility, utilizing vaccine furnished by the Secretary at no cost to the Veterans' Administration, and for such purpose, notwithstanding any other provision of law, the Secretary is authorized to provide such vaccine to the Veterans' Administration at no cost and the provisions of section 4116 of this title shall apply to claims alleging negligence or malpractice on the part of Veterans' Administration personnel granted immunity under such section.

"§ 663. Reports

"The Administrator shall include in the annual report to the Congress required by section 214 of this title a comprehensive report on the administration of this

subchapter, including such recommendations for additional legislation as the Administrator deems necessary."

(b) The table of sections at the beginning of such chapter is amended by inserting at the end thereof the following:

"SUBCHAPTER VII—PREVENTIVE HEALTH CARE PROGRAM

"660. Purpose.

"661. Definition.

"662. Preventive health care services; pilot program.

"663. Reports."

(c) Except with respect to the pilot program provided for in subsection (b) of section 662 (as amended by subsection (a) of this section) of title 38, United States Code, the amendments made by subsection (a) of this section shall be effective, with respect to services furnished, on and after January 1, 1977.

SEC. 111. Subsection (e) of section 1903 of title 38, United States Code, is amended by—

(1) striking out "or member of the Armed Forces" and inserting such language after "title" in paragraph (1); and

(2) inserting at the end thereof the following new paragraph:

"(3) Notwithstanding any other provision of law, the Administrator may obtain, by purchase, lease, gift, or otherwise, any automobile, motor vehicle, or other conveyance deemed necessary to carry out the purposes of this subsection, and may sell, assign, transfer, or convey any such automobile, vehicle, or conveyance to which the Veterans' Administration obtains title for such price and upon such terms as the Administrator deems appropriate; and any proceeds received from any such disposition shall be credited to the applicable Veterans' Administration appropriation."

SEC. 112. (a) Subchapter I of chapter 73 of title 38, United States Code, is amended by—

(1) amending subsection (b) of section 4106 to read as follows:

"(b) (1) Appointments under section 4104(1) of this title shall be for a probationary period of two years, and the record of each person serving under any such appointment shall be reviewed periodically by a board composed of employees appointed under this chapter, whose grades are comparable to or higher than the grade of the employee being reviewed, selected in accordance with regulations which the Administrator shall prescribe. If such board finds any probationary employee not fully qualified and satisfactory for reasons relating to professional competence or performance, such employee's probationary appointment may be terminated, such employee may be reassigned, or such employee may be subject to other nondisciplinary action consistent with continuing the employment of such employee in a capacity in which such employee can effectively function, in accordance with the procedures prescribed in paragraphs (2) and (3) of this subsection.

"(2) When it is proposed to take any action described in the second sentence of paragraph (1) of this subsection with respect to a probationary employee, such employee shall be entitled, before any such action is taken, to (A) a statement in writing of the reasons therefor and of any proposed finding with respect to professional competence or performance, (B) an opportunity to reply orally or in writing, or both, and (C) the assistance of any person of the employee's choice (not at Government expense) with regard to such reply.

"(3) If a board recommends that any action described in the second sentence of paragraph (1) of this subsection be taken, any such action shall be taken in accordance with the procedures prescribed in section 4110 (e) of this title.

"(4) When it is proposed to take disciplinary action against a probationary employee on grounds which constitute misconduct or would result in stigma, such employee shall be entitled, before any such action is taken, to the disciplinary board procedures prescribed in section 4110 of this title."

(2) amending section 4110 to read as follows:

"§ 4110. Disciplinary boards

"(a) When it is proposed to take disciplinary action for such cause (including inaptitude, ineffectiveness, or misconduct) as will promote the efficiency of the service against any person appointed under section 4104(1) of this title who has completed the probationary period provided for in section 4106(b) of this title, or when it is proposed to take disciplinary action on grounds which

constitute misconduct or would result in stigma against an employee appointed under (or identified in) section 4104(1) of this title who has not completed such probationary period (including part-time, temporary full-time, and intermittent employees appointed under section 4114(a) of this title and serving in positions identified in such section 4104(1) or a resident or intern appointed under section 4114(b) of this title, the Chief Medical Director shall cause to be appointed a disciplinary board. Such board shall hear and review charges on the basis of which disciplinary action is proposed and make findings and recommendations thereon, and shall operate in accordance with regulations which the Administrator shall prescribe pursuant to the provisions of this section. No disciplinary action shall be taken against any such employee until a final agency decision on such proposed action has been made.

"(b) Each such board shall consist of not less than three nor more than five employees appointed under this chapter, whose grades are comparable to or higher than the grade of the employee charged, and a minority of whom are of the same profession as such employee. The members of the board shall be selected by the Chief Medical Director in accordance with regulations which the Administrator shall prescribe.

"(c) The Chief Medical Director shall appoint the chairman of the board who shall be a member of the same profession as the employee charged. A member of the board shall be elected as secretary by a majority of the board. The chairman and secretary shall have authority to administer oaths to persons testifying before the board. The Chief Medical Director may designate or appoint one or more investigators to assist the board in the collection of evidence, and counsel may be designated to represent the Veterans' Administration.

"(d) Any employee answering to charges before a disciplinary board shall be entitled to (1) specification of charges, (2) a full hearing with opportunity to produce supportive witnesses and confront and cross-examine available witnesses, and (3) representation by a person of the employee's choice (not at Government expense) throughout the procedure prescribed in this section.

"(e) If a disciplinary board determines that any charge is sustained, it shall recommend to the Chief Medical Director such disciplinary action as it deems appropriate with respect to such charge, which may include, but is not limited to, reprimand, suspension without pay, reassignment, reduction in grade, and separation. The Chief Medical Director shall either (1) approve the findings and recommendation of the board, (2) approve such findings and recommendation with modification of the recommendation or exception to any finding or (3) disagree with such findings and recommendation, as to such charge. The Chief Medical Director shall make a final decision in writing on the matter under consideration (stating the reasons for such decision, for any modification of or disagreement with any board recommendation, and for any exception to any board finding), shall provide the employee with such written decision, and shall take appropriate action to effectuate such decision. In the event the Chief Medical Director purposes to take exception to a finding or modify a recommendation of the board, the Chief Medical Director may refer the matter to the board for reconsideration; if after such reconsideration by the board, the Chief Medical Director continues to take exception to any of its findings or to disagree with its recommendation, or both, the Chief Medical Director may make an independent review of the record before making a final decision under this section. The decision of the Chief Medical Director shall be the final agency decision.

"(f) The Chief Medical Director may, as disciplinary action under subsection (e) of this section, order the reassignment of any employee charged under this section. The Chief Medical Director may also reassign an employee for the good of the service and such reassignment shall not, in itself, entitle such employee to the disciplinary board procedures prescribed in this section. When such a reassignment for the good of the service would result in the reduction in grade, salary, or relative standing in the Department of Medicine and Surgery of an employee who has completed the probationary period prescribed by section 4106(b) of this title, such employee shall be entitled, before any such reassignment is effectuated, to the disciplinary board procedures prescribed in this section. When an employee alleges that a reassignment proposed for the good of the service is disciplinary in nature, the employee shall be entitled, before any such reassignment is effectuated, to attempt to sustain such allegation through the procedures prescribed by the Administrator to determine employee grievances. If such allegation is sustained in such grievance procedure, the employee shall be entitled,

before any such disciplinary action is taken, to the disciplinary board procedures prescribed in this section. For the purposes of this section, the term "reassignment" means the transfer of an employee from one duty station to another or from one set of responsibilities to another, within the Department of Medicine and Surgery."; and

(3) amending subsection (b) of section 4114 by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively, and by inserting below paragraph (1) the following new paragraph (2) :

"(2) In order to carry out the purposes of paragraph (1) of this subsection, the Chief Medical Director shall cause to be appointed, in accordance with regulations which the Administrator shall prescribe, House Staff Review Committees to review periodically the academic and professional performance and progress of persons appointed under paragraph (1) of this subsection. When it is proposed to take any action, such as reduction in grade, suspension without pay, or separation, with respect to a person appointed under such paragraph for reasons relating to professional or academic competence or performance, such person shall be entitled, before any such action is taken, to (A) a statement in writing of the reasons therefor and of any proposed finding with respect to professional or academic competence or performance, and (B) an opportunity to reply orally or in writing, or both, to the House Staff Review Committee. When it is proposed to take any such action with respect to a person appointed under paragraph (1) of this subsection on grounds which constitute misconduct or would result in stigma, such person shall be entitled, before any such action is effectuated to the disciplinary board procedures prescribed in section 4110 of this title."

(b) The amendment made by subsection (a) of this section with respect to the period of probationary service under section 4106 of title 38, United States Code, shall become effective as to probationary employees—

(1) one hundred and eighty days after the date of enactment of this Act, for those who on such enactment date have served eighteen months or more of their probationary period; or

(2) upon such enactment date for those who, on such date, have served less than eighteen months of their probationary period.

Sec. 113. Subchapter 1 of chapter 73 of title 38, United States Code, is further amended by—

(1) inserting at the end of section 4107 thereof the following new subsection;

"(g) When the Administrator finds such action to be necessary in order to obtain or retain the services of health care personnel to provide hospital care and medical services for veterans, the Administrator, notwithstanding any other provision of law, shall increase, on a nationwide basis the minimum or maximum rates of basic pay authorized under this chapter or title 5 for one or more grades or for one or more medical, dental, or health care fields within the grades, to (1) provide rates of basic pay commensurate with competitive pay practices in the same occupation or in order to achieve internal alignment of rates of basic pay within the Department of Medicine and Surgery, or (2) meet staffing requirements at Veterans' Administration facilities. Any such increase in the minimum rate of basic pay for any grade may not exceed the maximum rate prescribed pursuant to law for such grade. Any such increase in the maximum rate of basic pay for any grade may not exceed in corresponding amount, the rate provided for in the statutory range for that grade, subject to the limitation on the rate of basic pay fixed by administrative action set forth in section 5363 of title 5."; and

(2) inserting "(which may be established retroactively based on changes in such customary amount and terms)" after "pay" in subsection (b) (1) of section 4114.

Sec. 114. Subchapter 1 of chapter 73 of title 38, United States Code, is further amended by—

(1) inserting in section 4102 "a Podiatric Service, an Optometric Service," after "Dental Service,";

(2) striking out "and a Director of Optometry, appointed by the Administrator." and inserting in lieu thereof "a Director of Podiatric Service, and a Director of Optometric Service, appointed by the Administrator, and who shall be responsible to the Chief Medical Director for the operation of their respective Services." in clause (7) of subsection (a) of section 4103;

(3) amending section 4104 by—

(A) inserting "podiatrists, optometrists," after "dentists," in clause (1); and

(B) striking out "optometrists," in clause (2);

(4) redesignating clauses (5), (6), (7), and (8) in subsection (a) of section 4105 as clauses (6), (7), (8), and (9), respectively, and inserting after clause (4) the following new clause:

"(5) Podiatrist—

"hold the degree of doctor of podiatric medicine, or its equivalent, from a school of podiatric medicine approved by the Administrator, and be licensed to practice podiatry in a State;"

(5) inserting "podiatrists, optometrists," after "dentists," in subsections (a) and (c) and inserting "podiatrist, optometrist," after "dentist," in subsection (e) of section 4106;

(6) amending section 4107 by—

(A) (i) inserting in the SECTION 4103 SCHEDULE in subsection (a) "Director of Podiatric Service, \$36,338 minimum to \$46,026 maximum."; immediately below

"Director of Nursing Service, \$42,066 minimum to \$47,674 maximum.".

(ii) striking out "Director of Optometry" and inserting in lieu thereof "Director of Optometric Service" in such schedule in such subsection; and

(B) inserting immediately below the NURSE SCHEDULE in paragraph (1) of subsection (b) the following new schedule:

"CLINICAL PODIATRIST AND OPTOMETRIST SCHEDULE

"Chief grade, \$31,309 minimum to \$40,705 maximum.

"Senior grade, \$26,861 minimum to \$34,916 maximum.

"Intermediate grade, \$22,906 minimum to \$29,782 maximum.

"Full grade, \$19,386 minimum to \$25,200 maximum.

"Associate grade, \$16,255 minimum to \$21,133 maximum.";

(7) inserting "podiatrists, optometrists," after "dentists," and "podiatrist, optometrist," after "dentist," each place those words appear in the language preceding clause (1) and in subclause (B) of clause (6) of subsection (a) of section 4108;

(8) inserting "podiatric, optometric," after "dental," in subsection (a) of section 4112;

(9) inserting "podiatrists, optometrists," after "dentists," in section 4113;

(10) amending section 4114 by—

(A) inserting "podiatrists, optometrists," after "dentists," each place such term appears in paragraphs (1) (A) and (B) and (3) (A) and (B) of subsection (a); and

(B) striking out "or dentist" and inserting in lieu thereof a comma and "dentist, podiatrist, or optometrist" in the language preceding clause (1) of subsection (d) and in clause (1) of such subsection;

(11) inserting "podiatrist, optometrist," after "dentist," each place such word appears in subsection (a) of section 4116; and

(12) amending section 4117 by—

(A) striking out "medical schools," and inserting in lieu thereof "schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, and nursing,"; and

(B) inserting "podiatrists, optometrists," after "dentists,".

SEC. 115. (a) Chapter 73 of title 38, United States Code, is amended by inserting at the end thereof the following new subchapter:

"Subchapter III—Protection of Patient Rights

"§ 4131. Informed consent

"The Administrator, upon the recommendation of the Chief Medical Director and pursuant to the provisions of section 4134 of this title, shall prescribe regulations establishing procedures to ensure that all medical and prosthetic research carried out and, to the maximum extent practicable, all patient care furnished under this title shall be carried out only with the full and informed consent of the subject patient or, in appropriate cases, a representative thereof.

“§ 4132. Confidentiality of certain medical records

“(a) Records of the identity, diagnosis, prognosis, or treatment of any patient or subject which are maintained in connection with the performance of any program or activity (including education, training, treatment, rehabilitation, or research) relating to drug abuse, alcoholism or alcohol abuse, or sickle-cell anemia which is carried out by or for the Veterans' Administration under this title shall, except as provided in subsection (e) of this section, be confidential, and (section 3301 of this title to the contrary notwithstanding) such records may be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

“(b) (1) The content of any record referred to in subsection (a) of this section may be disclosed by the Administrator in accordance with the prior written consent of the patient or subject with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed by the Administrator pursuant to section 4134 of this title.

“(2) Whether or not any patient or subject, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives written consent, the content of such record may be disclosed by the Administrator as follows:

“(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

“(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient or subject in any report of such research, audit, or evaluation, or otherwise disclose patient or subject identities in any manner.

“(C) If authorized by an appropriate order of a United States court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient or subject, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

“(3) In the event that the patient or subject who is the subject of any record referred to in subsection (a) of this section is deceased, the content of any such record may be disclosed by the Administrator only upon the prior written request of the next of kin, executor, administrator, or other personal representative of such patient or subject and only if the Administrator determines that such disclosure is necessary for such survivor to obtain benefits to which such survivor may be entitled, including the pursuit of legal action, but then only to the extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed pursuant to section 4134 of this title.

“(c) Except as authorized by a court order granted under subsection (b) (2) (C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against, or to conduct any investigation of, a patient or subject.

“(d) The prohibitions of this section continue to apply to records concerning any person who has been a patient or subject, irrespective of whether or when such person ceases to be a patient.

“(e) The prohibitions of this section shall not prevent to any interchange of records—

“(1) within and among those facilities of the Veterans' Administration furnishing health care to veterans, or

“(2) between such facilities and the Armed Forces.

“(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

“§ 4133. Nondiscrimination in the admission of alcohol and drug abusers to Veterans' Administration health care facilities

“Veterans eligible for treatment under chapter 17 of this title who are alcohol or drug abusers and who are suffering from medical disabilities shall not be discriminated against in admission or treatment, solely because of their al-

cohol or drug abuse or dependence, by any Veterans' Administration health care facility. The Administrator, pursuant to the provisions of section 4134 of this title, shall prescribe regulations for the enforcement of this nondiscrimination policy with respect to the admission and treatment of such eligible veterans who are alcohol or drug abusers.

"§ 4134. Coordination; reports

"(a) Regulations prescribed pursuant to section 4131 of this title, section 4132 of this title with respect to the confidentiality of alcohol and drug abuse medical records, and section 4133 of this title, shall, to the maximum extent feasible consistent with other provisions of this title, make applicable the regulations governing—

"(1) human experimentation and informed consent prescribed by the Secretary of Health, Education, and Welfare, based on the recommendations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, established by section 201 of National Research Act, as amended (Public Law 93-348; 88 Stat. 348), and

"(2) (A) the confidentiality of drug and alcohol abuse medical records, and (B) the admission of drug and alcohol abusers to private and public hospitals, prescribed pursuant to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended (42 U.S.C. 4551 et seq.), and the Drug Abuse Office and Treatment Act of 1972, as amended (21 U.S.C. 1101 et seq.),

to the conduct of research and to the provision of hospital care, nursing home care, domiciliary care, and medical services under this title. Such regulations may contain such definitions, and may provide for such safeguards and procedures (including procedures and criteria for the issuance and scope of court orders under section 4132(b)(2)(C) of this title) as are necessary to prevent circumvention or evasion thereof, or to facilitate compliance therewith. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary of Health, Education, and Welfare, and, as appropriate, the Director of the Office of Drug Abuse Policy (or any successor authority), in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they and the Administrator prescribe.

"(b) Not later than sixty days after the date of enactment of this subsection, the Administrator shall submit to the appropriate committees of the House of Representatives and the Senate a full report with respect to the regulations (including guidelines, policies, and procedures thereunder) prescribed pursuant to subsection (a) of this section. Such report shall include (1) an explanation of any inconsistency between such regulations and the regulations of the Secretary referred to in such subsection (a); (2) an account of the extent, substance, and results of consultations with the Secretary (or Director, as appropriate) respecting the prescribing and implementation of the Administrator's regulations; and (3) such recommendations for legislation and administrative actions as the Administrator determines are necessary and desirable. The Administrator shall timely publish such report in the Federal Register."

(b) The table of sections at the beginning of such chapter is amended by adding at the end thereof:

"SUBCHAPTER III—PROTECTION OF PATIENT RIGHTS

"4131. Informed consent.

"4132. Confidentiality of certain medical records.

"4133. Nondiscrimination in the admission of alcohol and drug abusers to Veterans' Administration health care facilities.

"4134. Coordination; reports."

(c) The following provisions of law are superseded by the provisions of the amendments to chapter 73 of title 38, United States Code, made by subsection (a) of this section:

(1) Paragraph (2) of subsection (b) of section 321 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4551(b)(2)), as added by section 121(a) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (Public Law 93-282; 88 Stat. 130).

(2) Paragraph (2) of subsection (b) of section 407 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1174(b)(2)), as amended by section 6(a) of the Act entitled "An Act to amend the Drug Abuse Office and Treatment Act

of 1972, and for other purposes", approved March 19, 1976 (Public Law 94-237; 90 Stat. 244-5).

(3) Subsection (h) of section 408 of such 1972 Act (21 U.S.C. 1175(h)), as amended by section 303(b) (2) (B) of such 1974 Act (88 Stat. 137).

(4) Subsection (h) of section 333 of such 1970 Act (42 U.S.C. 4582(h)), as amended by section 122(a) of such 1974 Act (88 Stat. 131).

(5) Subsection (b) of section 121 of such 1970 Act (88 Stat. 131).

(6) Subsection (b) of section 6 of the Act entitled "An Act to amend the Drug Abuse Office and Treatment Act of 1972, and for other purposes", approved March 19, 1976 (90 Stat. 245).

(7) Subsection (c) of section 303 of such 1974 Act (88 Stat. 139).

(8) Subsection (c) of section 122 of such 1974 Act (88 Stat. 133).

SEC. 116. (a) Subsection (a) of section 4118 of title 38, United States Code, is amended by—

(1) inserting "in professional or administrative positions or clinical research positions in the career development program" after "dentists" in paragraph (1); and

(2) inserting "professional and administrative" after "of" in paragraph (3).

(b) Section 6(a) (2) of the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975 (Public Law 94-123; 89 Stat. 669) is amended by striking out "October 11, 1976" and inserting in lieu thereof "June 30, 1977, or the expiration date of the authority contained in section 313 of title 37, United States Code, to provide special pay to physician medical officers in the uniformed services, whichever is later".

SEC. 117. Section 4123 is amended by adding at the end thereof the following new sentence: "Any proceeds to the Government received therefrom shall be credited to the applicable Veterans' Administration medical appropriation."

SEC. 118. Chapter 75 of title 38, United States Code is amended by—

(1) amending section 4204 by—

(A) inserting "(a)" before "To"; and

(B) inserting at the end thereof the following new subsection:

"(b) Without regard to fiscal year limitations, obligations may be incurred against anticipated budgetary resources of the Service revolving fund in such amounts and for such periods as the Administrator may determine to be necessary to maintain and continue operations without incurring over-obligations at any time during the fiscal year."; and

(2) amending section 4206 by—

(A) striking out "year" the first place it appears in the first sentence and the second place it appears in the second sentence and inserting in lieu thereof "five fiscal years"; and

(B) inserting at the end thereof the following new sentence: "In determining estimated requirements, the Service may provide for such capital improvements to canteen facilities, including those which are constructed and become a part of the building or structure, as may be approved by the Director of the Office of Management and Budget and included in the budget required to be submitted to Congress pursuant to section 201 of Budget and Accounting Act, 1921 (31 U.S.C. 11)".

SEC. 119. Subsection (a) (3) of section 5001 of title 38, United States Code, is amended by striking out "eight thousand beds in the fiscal year ending June 30, 1974," and inserting in lieu thereof "ten thousand beds in fiscal year 1980".

SEC. 120. (a) Subchapter IV of chapter 81 of title 38, United States Code, is amended by—

(1) adding at the end of subsection (b) of section 5052 the following new sentence: "Such term also means emergency room medical resources which the Administrator determines are necessary for the treatment of veterans whose eligibility for medical services has been established under section 612(a) or 612(f) (1) (B) or (2) in medical emergencies which pose a serious threat to life or health but which would be unduly costly and duplicative to provide directly in a Veterans' Administration facility.";

(2) inserting at the end of section 5053 the following new subsection: "(d) When a Veterans' Administration health care facility provides hospital care or medical services, pursuant to a contract or agreement authorized by this section, to an individual who is entitled to hospital or medical insurance benefits under subchapter XVIII of chapter 7 of title 42, such benefits shall be paid,

notwithstanding any condition, limitation, or other provision in that title which would otherwise preclude such payment, in accordance with—

“(1) rates prescribed by the Secretary of Health, Education, and Welfare, after consultation with the Administrator, and

“(2) procedures jointly prescribed by the Secretary and the Administrator to assure reasonable quality of care and services and efficient and economical utilization of resources,

to such facility therefor or, if the contract or agreement so provides, to the community health care facility which is a party to the contract or agreement.”;

(3) amending section 5056 by—

(A) amending the catchline to read as follows:

“§ 5056. Coordination with health services development activities carried out under the National Health Planning and Resources Development Act of 1974”; and

(B) striking out “title IX” and inserting in lieu thereof “part F of title XVI”; and

(4) inserting at the end of such subchapter the following new sections:

“§ 5058. Coordination with programs carried out under title XI of the Social Security Act

“(a) The Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, attempt to coordinate the Professional Standards Review program carried out under part B of title XI of the Social Security Act and the comparable programs carried out by the Department of Medicine and Surgery to assess the quality of patient care in Veterans' Administration health care facilities. Such coordination shall include sharing of information with regard to norms of health care services developed on a regional and national basis and arrangements for joint memberships on entities established by the Department of Medicine and Surgery and entities established under such Act.

“(b) Not later than one year after the date of enactment of this section, and annually thereafter, the Chief Medical Director shall report to the Congress on the effectiveness of such coordination in improving the evaluation of the quality of patient care provided by the Department of Medicine and Surgery and in achieving the purposes of the program carried out under such Act.

“§ 5059. Reports on coordination with other programs

“Not later than three months after the end of each fiscal year, the Chief Medical Director, through the Administrator, shall report to the Congress on all activities (and the results thereof) in which the Chief Medical Director or a designee, as a representative of the Veterans' Administration, has participated, as a result of a statutory requirement or otherwise, in an advisory or coordinating capacity with respect to programs carried out by other departments, agencies, or instrumentalities of the executive branch.”.

(b) The table of sections at the beginning of such chapter is amended by—

(1) striking out

“5056. Coordination with programs carried out under the Heart Disease, Cancer, and Stroke Amendments of 1965.”

and inserting in lieu thereof

“5056. Coordination with health services development activities carried out under the National Health Planning and Resources Development Act of 1974.”;

and

(2) inserting at the end thereof

“5058. Coordination with programs carried out under title XI of the Social Security Act.

“5059. Reports on coordination with other programs.”.

SEC. 121. Chapter 82, of title 38, United States Code, is amended by—

(1) redesignating subsections (e) and (f) of section 5070 as subsections (f) and (g), respectively, and inserting the following new subsection (e):

“(e) In carrying out the purposes of this chapter, the Administrator may lease to any eligible institution for such consideration and under such terms and conditions as the Administrator deems appropriate, such land, buildings, and structures (including equipment therein) under the control and jurisdiction of the Veterans' Administration as may be necessary. The three-year limitation on the term of a lease prescribed in section 5012(a) of this title shall not apply with re-

spect to any lease entered into pursuant to this chapter. Any lease entered into pursuant to this chapter may be entered into without regard to the provision of section 3709 of the Revised Statutes (41 U.S.C. 5). Notwithstanding section 321 of the Act entitled 'An Act making appropriations for the Legislative Branch of the Government for the fiscal year ending June 30, 1933, and for other purposes', approved June 30, 1932 (40 U.S.C. 303b), or any other provision of law, a lease entered into pursuant to this chapter may provide for the maintenance protection, or restoration, by the lessee, of the property leased, as a part or all of the consideration of the lease." ;

(2) inserting at the end of section 5070 the following new subsection :

"(h) Not later than ninety days after the end of each fiscal year, the Administrator shall submit to the Congress a report on activities carried out under this chapter, including (1) an appraisal of the effectiveness of the programs authorized herein in carrying out their statutory purposes and the degree of cooperation from other sources, financial and otherwise, (2) an appraisal of the contributions of such programs in improving the quantity and quality of physicians and other health care personnel furnishing hospital care and medical services to veterans under this title, (3) a list of the approved but unfunded projects under this chapter and the funds needed for each such project, and (4) recommendations for the improvement of more effective administration of such programs, including any necessary legislation." ;

(3) striking out paragraph (1) of subsection (a) of section 5073 and redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively ; and

(4) striking out "subsections (a)(1) and" and inserting in lieu thereof "section 5070(e) of this title and subsection" in section 5073(b)(2).

Sec. 122. (a) The Chief Medical Director of the Department of Medicine and Surgery of the Veterans' Administration shall carry out or provide for a study to determine the short-range and long-range direction of the hospital and medical program carried out under title 38, United States Code, for eligible veterans and persons with reference to the increasing average age of the eligible veteran population. Not later than twelve months after the date of enactment of this Act, the Chief Medical Director, through the Administrator of Veterans' Affairs, shall submit to the appropriate Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the results of such study, including, but not limited to, specific plans for—

(1) adjusting the number of Veterans' Administration hospital, nursing home, intermediate care, and domiciliary beds ;

(2) adjusting the program for contracting for such nursing home care (including intermediate and personal care) in community facilities ;

(3) expanding alternatives to institutional care, including provision of home health (including homemaker and special nutrition) services ;

(4) emphasizing treatment programs particularly suited to meeting the health care needs of an aging population ;

(5) emphasizing education and training of health care personnel specializing in the treatment of elderly persons and diseases and infirmities characteristic of an aging population ;

(6) emphasizing biomedical and health services research designed to ameliorate geriatric care problems ; and

(7) meeting the special architectural, transportation, and environmental needs of an aging population.

(b) Not later than ninety days after the date of enactment of this Act, the Administrator shall take all appropriate steps to ensure that, to the maximum extent feasible, each individual eligible for new or expanded care and services as a result of the amendments made by this Act is personally notified, in a clear and simple manner, about such new or expanded eligibility and the way to secure such care and services, and shall send copies of all such notification forms to the appropriate committees of the House of Representatives and the Senate, along with a description of how such forms were distributed.

TITLE II—VETERANS DRUG AND ALCOHOL TREATMENT AND REHABILITATION AMENDMENTS

SEC. 201. This title may be cited as the "Veterans Drug and Alcohol Treatment and Rehabilitation Act of 1976".

SEC. 202. Paragraph (1) of section 601 of title 38, United States Code, is amended by inserting "(including alcoholism and drug dependence)" after "disease".

SEC. 203. (a) Subchapter II of chapter 17 of title 38, United States Code, is amended by inserting at the end thereof the following new section:

"§ 620A. Treatment and rehabilitation for alcoholism

"(a) The Congress hereby finds and declares that alcoholism and alcohol abuse are among the most pervasive untreated diseases and disabilities afflicting the Nation, including the veteran population, and that the onset of alcoholism and alcohol abuse often occurs during military service.

"(b) In order to meet the situation described in subsection (a) of this section, the Administrator, in carrying out the responsibilities to furnish hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, shall carry out specialized medical programs providing inpatient treatment (including treatment of the symptoms of detoxification), outpatient treatment, and rehabilitative services on a nationwide basis to eligible veterans suffering from the disability of alcoholism or alcohol abuse. In carrying out such specialized medical programs, the Administrator (1) shall utilize the most efficacious available treatment and rehabilitation modalities (stressing the utilization in such programs of counselors who are recovered alcoholics, half-way houses, and encounter-style therapeutic communities) extending beyond the detoxification period and designed to provide for the full recovery of the patient and the restoration of such patient to society as a productive, self-sufficient citizen, and (2) may utilize private half-way-house facilities for which the Administrator contracts in accordance with regulations which the Administrator shall prescribe. Under the circumstances described in the last sentence of section 672(b) of this title, the Administrator shall arrange for the provision of treatment and rehabilitative services, at Veterans' Administration expense, in approved community facilities for which the Administrator contracts to veterans suffering from the disability of alcoholism or alcohol abuse.

"(c) The Administrator shall submit annually (as a part of the annual report submitted pursuant to section 214 of this title) a full report on the programs carried out under this section, including the same type of information specified in section 677 of this title."

(b) The table of sections at the beginning of such chapter is amended by inserting

"620A. Treatment and rehabilitation for alcoholism."

below

"620. Transfers for nursing home care."

SEC. 204. (a) Chapter 17 of title 38, United States Code (as amended by section 110 of this Act), is amended by inserting at the end thereof the following new subchapter:

"Subchapter VIII—Special Medical Treatment and Rehabilitative Services for Drug Dependence or Drug Abuse Disabilities

"§ 671. Definition

"As used in this subchapter and notwithstanding any other provision of this title, the term 'veteran' includes (except as otherwise provided in section 3103 of this title) a person who served in the active military, naval, or air service and who was discharged or released therefrom with other than a dishonorable discharge.

"§ 672. Treatment and rehabilitative services for veterans suffering from drug dependence or drug abuse disabilities

"(a) The Administrator shall furnish to any veteran with a drug dependence or drug abuse disability such special medical treatment and rehabilitative services and such hospital, nursing home, and domiciliary care (hereinafter in this subchapter collectively referred to as treatment and rehabilitative services) as the Administrator finds to be reasonably necessary to bring about the veteran's recovery and rehabilitation from such disability.

"(b) Such treatment and rehabilitative services—

"(1) shall (A) include, but not be limited to, in addition to those services described in section 601 of this title, individual counseling and referral

services and crisis intervention, and (B) be provided in hospital, domiciliary, outpatient, and half-way-house and other community-based facilities (including satellite facilities located in areas where large numbers of veterans eligible for treatment and rehabilitative services under this subchapter reside) over which the Administrator has direct jurisdiction; and

"(2) may be provided in private half-way-house facilities for which the Administrator contracts in accordance with such regulations as the Administrator shall prescribe.

If the Administrator determines that it is essential to the successful treatment and rehabilitation of a veteran receiving initial evaluation or treatment under this subchapter or section 620A of this title that treatment and rehabilitative services (involving the furnishing of medication) be furnished in the same program to a member of the veteran's immediate family who is suffering from a drug or alcohol abuse or dependence disability, then the Administrator shall offer the veteran the provision of, and provide if requested, like treatment and services, at Veterans' Administration expense (up to costs deemed reasonable by the Administrator), in community facility, approved by the Administrator, for which the Administrator contracts and at which such family member has been accepted for treatment (not at Veterans' Administration expense) with the veteran.

"(c) In providing for treatment and rehabilitative services under this subchapter to any veteran, the Administrator shall offer alternative modalities of treatment based upon the individual needs of such veteran.

"(d) In contracting for treatment and rehabilitative services in facilities outside the Veterans' Administration pursuant to this subchapter, the Administrator shall, wherever feasible, give priority to community-based, multiple-modality, treatment and rehabilitation programs which employ peer group veterans and stress outreach efforts to identify and counsel veterans eligible for treatment and rehabilitative services under this subchapter.

"(e) The Administrator shall, upon receipt of application for treatment and rehabilitative services under this subchapter by any veteran who has been discharged or released from a period of active military, naval, or air service, with other than an honorable or general discharge—

"(1) advise such veteran of the right to apply to the appropriate military, naval, or air service for a review of the nature of such discharge or release for the purpose of correcting the nature of such discharge and thus removing any ineligibility to the receipt of benefits under this title or any other law;

"(2) advise such veteran of the policy of the Armed Forces with respect to review of the nature of any discharge received in connection with drug use or possession; and

"(3) advise such veteran of all program benefits under this title and any other law to which such veteran is entitled or would be entitled with a general or honorable discharge.

The Administrator shall offer and, if requested, provide to any veteran within the purview of this subsection such assistance as may be necessary to facilitate the process of preparing and filing an application for a review of the nature of such veteran's discharge or release from a period of active military, naval, or air service.

"(f) (1) The Administrator shall also provide for treatment and rehabilitative services in the case of any veteran eligible therefor under this subchapter who has been charged with, or convicted of, a criminal offense by any court of competent jurisdiction in the United States, who is not confined and who is not required to participate in the treatment and rehabilitation program by any such court.

"(2) The Administrator may also provide for treatment and rehabilitative services to any veteran eligible therefor under this subchapter who is under the jurisdiction of a court of competent jurisdiction as the result of having been charged with, or having been convicted of, a criminal offense and who is required to participate in a treatment and rehabilitation program by such court, but such services may be provided only under such conditions as the Administrator determines will ensure that the participation of such veteran in the program in question will not impair the voluntary nature of the treatment and rehabilitative services being provided to other patients in such program.

"§ 673. Outreach and counseling

"(a) The Administrator shall utilize all available resources of the Veterans' Administration, including the use of peer-group veterans, in seeking out and counseling toward treatment and rehabilitation of all veterans, especially veterans who served after August 4, 1964, eligible for treatment and rehabilitative services under this subchapter.

"(b) The Administrator shall take affirmative steps, in consultation with the Secretary of Labor and the Chairman of the Civil Service Commission, to (1) urge all Federal agencies, private and public firms, organizations, agencies, and persons to provide appropriate employment and training opportunities for veterans provided treatment and rehabilitative services under this subchapter and under section 620A of this title who have been determined by competent medical authority to be sufficiently rehabilitated to be employable, and (2) provide all possible assistance to the Secretary of Labor in placing such veterans in such opportunities.

"§ 674. Audits by Comptroller General

"(a) The Comptroller General of the United States, or any duly authorized representative thereof, shall have access for the purpose of audit and examination to any books, accounts, records, reports, files, and all other things or property of facilities outside the Veterans' Administration that are pertinent to payments received pursuant to contracts entered into under this subchapter.

"(b) The Comptroller General shall carry out the responsibilities under this section in such a way as to comply with the provisions set forth in section 4132 of this title with respect to medical confidentiality.

"§ 675. Budget requests

"For fiscal year 1977, and for each fiscal year thereafter, there shall be included in the budget required to be submitted to Congress pursuant to section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11), a separate line item showing the estimated expenditures by the Veterans' Administration under this subchapter and under section 620A of this title during such fiscal year for the treatment and rehabilitation of eligible veterans.

"§ 676. Treatment of members of the Armed Forces by the Veterans' Administration

"(a) Any member of the active military, naval, or air service who is determined by the Secretary of the military department concerned to have a drug dependence or drug abuse disability, may, pursuant to such terms as may be agreed upon by the Secretary concerned and the Administrator, and subject to the provisions of the Act of March 4, 1915, as amended (31 U.S.C. 686), be transferred to any Veterans' Administration facility within the last thirty days of such member's tour of duty and be provided treatment and rehabilitative services under this subchapter as if such member were a veteran.

"(b) The Administrator shall from time to time make a report to the Secretary concerned as to the progress of the treatment of any member transferred pursuant to the provisions of this section, and the Administrator shall release such member to the Secretary concerned when the Administrator finds that the drug abuse disability of such member is stabilized, or certifies that (1) such member refuses to comply with the terms and conditions of the treatment prescribed, or (2) the treatment which could otherwise be provided will be of no further benefit to such member.

"(c) No member of the active military, naval, or air service shall be transferred to any Veterans' Administration facility pursuant to subsection (a) of this section unless such member requests such transfer in writing for a specified period of time within such member's tour of duty. No such member thereafter transferred shall be retained for treatment by the Administrator beyond such specified period of time within such member's tour of duty unless the member requests in writing treatment for a further specified period of time and such request is approved by the Secretary concerned and the Administrator.

"§ 677. Reports

"Not later than six months after the date of the enactment of this section and thereafter on May 1 of each year, the Administrator shall submit to the appropriate committees of the House of Representatives and the Senate a full report (covering the period since any prior report under this section) on the implementa-

tion of this subchapter and section 620A of this title separately with respect to alcoholism and alcohol abuse, on the one hand, and to drug dependency and abuse on the other, and an evaluation of the effectiveness of alternate treatment and rehabilitation programs provided hereunder and under such section 620A, including (1) the number of veterans and servicemen provided treatment and/or rehabilitative services, (2) the average duration of such treatment and/or services, (3) the estimated percentage of successful rehabilitation and enduring recovery cases, (4) an analysis of successful and unsuccessful rehabilitation experience, (5) a description of outreach, information dissemination, and job development and placement efforts, (6) a full accounting of payments to, and an evaluation of services and programs provided in, facilities outside the Veterans' Administration, (7) experience under the medical confidentiality provisions in section 4132 of this title, (8) plans for new program directions, and (9) such recommendations for legislation as the Administrator deems appropriate."

(b) The table of sections at the beginning of chapter 17 of title 38, United States Code, is amended by inserting at the end thereof the following:

**"SUBCHAPTER VIII—SPECIAL MEDICAL TREATMENT AND REHABILITATIVE SERVICES FOR
DRUG DEPENDENCE OR DRUG ABUSE DISABILITIES**

- "Sec.
 "671. Definition.
 "672. Treatment and rehabilitative services for veterans suffering from drug dependence or drug abuse disabilities.
 "673. Outreach and counseling.
 "674. Audits by Comptroller General.
 "675. Budget requests.
 "676. Treatment of members of the Armed Forces by the Veterans' Administration.
 "677. Reports."

TITLE III—MEDICAL TECHNICAL AND CONFORMING AMENDMENTS

SEC. 301. This title may be cited as the "Veterans Medical Technical and Conforming Amendments of 1976".

SEC. 302. Chapter 17 of title 38, United States Code, is amended as follows:

(a) The title of such chapter is amended by inserting "NURSING HOME," before "**DOMICILIARY**".

(b) Section 601 is amended by—

(1) striking out "and exclusive" in clause (A) of paragraph (4);

(2) (A) inserting after "contracts" in clause (C) of paragraph (4) "when facilities described in clause (A) or (B) of this paragraph are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the care or services required";

(B) redesignating subclauses (ii) and (iii) of such clause (C) as subclauses (iv) and (v), respectively;

(C) striking out subclause (i) of such clause (C) and inserting in lieu thereof the following subclauses: "(i) hospital care or medical services to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service; (ii) medical services for the treatment of any disability of a veteran described in clause (1) (B) or (2) of section 612(f) of this title; (iii) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care in a facility described in clause (A) or (B) of this paragraph;"; and

(D) striking out "clause (iii)" where the term appears in subclause (v) (as so redesignated) of such clause (C) and inserting in lieu thereof "subclause (v)"; and

(3) striking out in subclause (ii) of clause (A) of paragraph (5) "for any veteran who is in need of treatment for a service-connected disability or is unable to defray the expense of transportation" and inserting in lieu thereof "pursuant to the provisions of section 111 of this title".

(c) The subchapter heading at the beginning of subchapter II of such chapter is amended by inserting a comma and "Nursing Home," after "Hospital".

(d) Section 610 is amended by—

(1) inserting a comma and "nursing home," after "hospital" in the catchline of such section;

- (2) inserting "or nursing home" after "hospital" in subsection (a) (1) (B) ;
 - (3) striking out "of any war or of service after January 31, 1955," and the comma after "domiciliary care" in subsection (b) (2) ; and
 - (4) striking out "and exclusive" in subsection (d).
- (e) (1) The catchline of section 611 is amended by striking out "Hospitalization" and inserting in lieu thereof "Care".

(2) Subsection (b) of section 611 is amended by inserting "or medical services" after "hospital care".

(f) Section 612 is amended by—

(1) striking out "Indian wars" and inserting in lieu thereof "Indian Wars" in subsection (e) ;

(2) striking out "granted" and inserting in lieu thereof "furnished" in subsection (f) (1) (B) ; and

(3) inserting after "Administrator" in subsection (g) a comma and "with- in the limits of Veterans' Administration facilities,".

(g) Section 616 is amended by striking out "Bureau of the Budget" and inserting in lieu thereof "Office of Management and Budget".

(h) Subsection (a) of section 620 is amended by—

(1) striking out "and exclusive" in clause (1) and in the last sentence of such subsection; and

(2) striking out "from time to time" and inserting in lieu thereof "an- nually" in clause (ii).

(i) The subchapter heading at the beginning of subchapter III of such chapter is amended by inserting "and Nursing Home" after "Hospital".

(j) Clauses (1) through (3) of section 621 are amended by inserting a comma and "nursing home," after "hospital" each time it appears.

(k) Subsection (a) of section 622 is amended by striking out "610(a)(1)" and inserting in lieu thereof "610(a)(1)(B)", and by striking out "632(b)" and inserting in lieu thereof "632(a)(2)".

(l) Subsection (c) of section 624 is amended by striking out "of any war" after "veteran".

(m) Section 627 is amended by striking out "1955" and inserting in lieu thereof "1957".

(n) Subsection (a) (1) of section 628 is amended by striking out "they" and inserting in lieu thereof "delay".

(o) Section 641 is amended by striking out "of any war or of service after January 31, 1955".

(p) Section 643 is amended by striking out "of any war" after "veteran".

SEC. 303. (a) The table of chapters and parts at the beginning of title 38, United States Code, and the table of chapters at the beginning of part II of such title are each amended by inserting in the title of chapter 17 "NURSING HOME," after "HOSPITAL".

(b) The table of sections at the beginning of chapter 17 of such title is amended by—

(1) inserting in the heading of subchapter II a comma and "NURSING HOME," after "HOSPITAL";

(2) inserting in the item relating to section 610 a comma and "nursing home" after "hospital";

(3) inserting in the heading of subchapter III "AND NURSING HOME" after "HOSPITAL"; and

(4) striking out "Hospitalization" and inserting in lieu thereof "Care" in the item relating to section 611.

SEC. 304. Chapter 23 of title 38, United States Code, is amended by inserting in subsection (a) of section 903 a comma and "nursing home," after "hospital", and by striking out "611" and inserting in lieu thereof "611(a)" in such subsection.

SEC. 305. Subchapter I of chapter 73 of title 38, United States Code, is amended as follows:

(a) (1) The second sentence of subsection (a) of section 4101 is amended to read as follows: "The primary function of the Department of Medicine and Surgery shall be to provide a complete medical and hospital service, as provided in this title and in regulations prescribed by the Administrator pursuant thereto, for the medical care and treatment of veterans.".

(2) Subsection (b) of section 4101 is amended by striking out "to provide a complete medical and hospital service for the medical care and treatment of veterans".

(3) Section 4101 is further amended by redesignating subsection (c) as subsection (d) and inserting the following new subsection (c) :

"(c) (1) In order to carry out more effectively the primary function of the Department of Medicine and Surgery and in order to contribute to the Nation's knowledge about disease and disability, the Administrator shall, in connection with the provision of medical care and treatment to veterans, carry out a program of medical research (including biomedical, prosthetic, and health care services research, and stressing research into spinal cord injuries and diseases and other disabilities that lead to paralysis of the lower extremities). In carrying out such research program, the Administrator shall act in cooperation with the entities described in subsection (b) of this section.

"(2) Prosthetic research shall include research and testing in the field of prosthetic, orthotic, and orthopedic appliances and sensory devices. In order that the unique investigative material and research data in the possession of the Government may result in the improvement of such appliances and devices for all disabled persons, the Administrator, through the Chief Medical Director, shall make the results of such research available to any person, and shall consult and cooperate with the Secretary of Health, Education, and Welfare and the Commissioner of the Rehabilitation Services Administration, Department of Health, Education, and Welfare, in connection with programs carried out under section 3(b) of the Rehabilitation Act of 1973 (Public Law 93-112; 87 Stat. 357) (relating to the development and support, and the stimulation of the development and utilization, including production and distribution of new and existing devices, of innovative methods of applying advanced medical technology, scientific achievement, and psychological and social knowledge to solve rehabilitation problems), section 202(b)(2) of such Act (relating to the establishment and support of Rehabilitation Engineering Research Centers), and section 405 of Act (relating to the secretarial responsibilities for planning, analysis, promoting utilization of scientific advances, and information clearing-house activities).

"(3) (A) With the approval of the Administrator, any contract for research authorized by this section, the performance of which involves a risk of an unusually hazardous nature, may provide that the United States will indemnify the contractor against either or both of the following, but only to the extent that they arise out of the direct performance of the contract and to the extent not covered by the financial protection required under subparagraph (E) of this paragraph :

"(i) Liability (including reasonable expenses of litigation or settlement) to third persons, except liability under State or Federal workers' injury compensation laws to employees of the contractor employed at the site of and in connection with the contract for which indemnification is granted, for death, bodily injury, or loss of or damage to property, from a risk that the contract defines as unusually hazardous.

"(ii) Loss of or damage to property of the contractor from a risk that the contract defines as unusually hazardous.

"(B) A contract that provides for indemnification in accordance with subparagraph (A) of this paragraph must also provide for—

"(i) notice to the United States of any claim or suit against the contractor for death, bodily injury, or loss of or damage to property; and

"(ii) control of or assistance in the defense by the United States, at its election, of any such suit or claim for which indemnification is provided hereunder.

"(C) No payment may be made under subparagraph (A) of this paragraph unless the Administrator, or the Administrator's designee, certifies that the amount is just and reasonable.

"(D) Upon approval by the Administrator, payments under subparagraph (A) of this paragraph may be made from—

"(i) funds obligated for the performance of the contract concerned ;

"(ii) funds available for research or development or both, and not otherwise obligated ; or

"(iii) funds appropriated for those payments.

"(E) Each contractor which is a party to an indemnification agreement under subparagraph (A) of this paragraph shall have and maintain financial protection of such type and in such amounts as the Administrator shall require to cover liability to third persons and loss of or damage to the contractor's property. The

amount of financial protection required shall be the maximum amount of insurance available from private sources, except that the Administrator may establish a lesser amount, taking into consideration the cost and terms of private insurance. Such financial protection may include private insurance, private contractual indemnities, self-insurance, other proof of financial responsibility, or a combination of such measures.

"(F) In administering the provisions of this paragraph, the Administrator may use the facilities and services of private insurance organizations, and may contract to pay a reasonable compensation therefor. Any contract made under the provisions of this paragraph may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5), upon a showing by the Administrator that advertising is not reasonably practicable, and advance payments may be made under any such contract.

"(G) The authority to indemnify contractors under this paragraph does not create any rights in third persons which would not otherwise exist by law.

"(H) As used in this section, the term 'contractor' includes subcontractors of any tier under a contract containing an indemnification provision pursuant to subparagraph (A) of this paragraph.

"(4) Funds appropriated to carry out this subsection shall remain available until expended."

(b) Chapter 39 of title 38, United States Code, is amended by—

(1) striking out in the table of sections

"1904. Research and development; coordination with other Federal programs."

and inserting in lieu thereof:

"1904. Research and development." ;

(2) amending the catchline of section 1904 to read as follows:

"§ 1904. Research and development"; and

(3) amending subsection (a) of section 1904 by striking out "prosthetic and orthopedic appliance research under section 216 and medical research" and inserting in lieu thereof "medical and prosthetic research".

(c) Chapter 3 of title 38, United States Code, is amended by—

(1) striking out section 216 in its entirety; and

(2) amending the table of sections at the beginning thereof by striking out

"216. Research by the Administrator; indemnification of contractors."

(d) Section 4103 of such title is amended by—

(1) inserting "upon the recommendation of the Chief Medical Director" after "Administrator" in paragraphs (2) and (3) of subsection (a);

(2) striking out "recommendations" and inserting in lieu thereof "recommendation" in subsection (a) (4);

(3) inserting "or whose appointment or reappointment is extended" after "reappointed" in subsection (b) (3); and

(4) inserting "or for any period not exceeding two years" in subsection (c) before the period at the end of the second sentence.

(e) Subsection (a) (6) (as redesignated by section 114(4) of this Act) of section 4105 of title 38, United States Code, is amended by inserting "hold the degree of doctor of optometry, or its equivalent, from a school of optometry approved by the Administrator and" before "be".

(f) Subsection (b) of section 4108 is amended by striking out "pursuant to" after "agreement" and inserting in lieu thereof "as referred to in".

(g) Subsection (b) of section 4114 is amended by amending paragraph (3) (as redesignated by section 112(a) (3) of this Act) to read as follows:

"(3) For the purposes of this title, the term 'internship' shall include the equivalency of an internship as determined in accordance with regulations which the Administrator shall prescribe, and the term 'intern' shall mean a person serving an internship."

SEC. 306. Chapter 81 of title 38, United States Code, is amended as follows:

(a) Section 5001 is amended by—

(1) striking out "and exclusive" in the first sentence of subsection (a) (2), and striking out "tuberculosis" and inserting in lieu thereof "tuberculosis" in such sentence; and

(2) striking out "and exclusive" in the first sentence of subsection (a) (3).

(b) Subchapter III of such chapter is amended by striking out "war" each time it appears in paragraph (a) of section 5031, section 5032, paragraph (1) of section 5034, paragraphs (4) of subsections (a) and (b) of section 5035, and section 5036.

(c) Section 5053 is amended by—

(1) striking out "paragraphs" and inserting in lieu thereof "clauses" in the first sentence of subsection (a) ; and

(2) inserting "health care" after "Veterans' Administration" each place it appears in clauses (1) and (2) of subsection (a) and in subsection (c).

(d) Subsection (b) of section 5054 is amended by inserting "the" before "surrounding medical community" the second place it appears.

(e) The second sentence of subsection (a) of section 5055 is amended by striking out "for Research and Education in Medicine" and inserting in lieu thereof "charged with administration of the Department of Medicine and Surgery medical research program".

SEC. 307. Subchapter II of chapter 82 of title 38, United States Code, is amended by striking out "subchapter IV of chapter 81 of" in subsection (a) of section 5083.

SEC. 308. Chapter 85 of title 38, United States Code, is amended as follows:

(a) The first sentence of subsection (b) of section 5202 is amended by inserting "or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title," after "(admitted as a veteran)", in the first sentence.

(b) Subsection (a) of section 5220 is amended by inserting a comma and "or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title," after "(admitted as a veteran)".

(c) Section 5221 is amended by inserting a comma and "or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title," after "(admitted as such)".

SEC. 309. (a) Subchapter I of chapter 73 of title 38, United States Code, is amended as follows:

(1) Subsection (b) of section 4101, clause (1) of section 4104, subsection (b) of section 4105, subsection (f) of section 4106, subsection (f) of section 4107, the language preceding clause (1) in subsection (a) and clause (6) (B) in subsection (a) of section 4108, and section 4117, are each amended by striking out "physicians" and inserting in lieu thereof "physician".

(2) Clause (1) of section 4104, clause (8) of subsection (a) and subsection (b) of section 4105, subsection (f) of section 4107, and the language preceding clause (1) in subsection (a) and subclause (B) of clause (6) of subsection (a) of section 4108 are each amended by striking out "expanded-duty" each place it appears and inserting in lieu thereof "expanded-function".

(3) Subsection (b) of section 4101 is further amended by striking out "dentists' assistants" and inserting in lieu thereof "expanded-function dental auxiliaries".

(4) Clause (8) of subsection (a) of section 4105 is further amended by striking out "Physicians" and inserting in lieu thereof "Physician".

(5) Section 4113 is amended by striking out "and nurses" and inserting in lieu thereof "nurses, physician assistants, and expanded-function dental auxiliaries".

(6) Section 4114 is amended by—

(A) inserting "physician assistants, expanded-function dental auxiliaries," after "nurses," in clauses (A) and (B) of subsection (a) (1) ;

(B) striking out "and nurses" and inserting in lieu thereof "nurses, physician assistants, and expanded-function dental auxiliaries" in the first sentence of subsection (a) (3) (A) ;

(C) striking out "nurses and interns, and" and inserting in lieu thereof "nurses, physician assistants, expanded-function dental auxiliaries, and interns," in subsection (a) (3) (B) ; and

(D) striking out "dentist's assistant" and inserting in lieu thereof "expanded-function dental auxiliary" in the first sentence of subsection (e).

(7) Subsection (a) of section 4116 is amended by striking out "physicians' assistant, dentists' assistant" each time those terms appear and inserting in lieu thereof "physician assistant, expanded-function dental auxiliary".

(8) Section 4117 is amended by striking out "dentists' assistants" and inserting in lieu thereof "expanded-function dental auxiliaries".

(b) Subchapter I of chapter 73 of title 38, United States Code, is further amended as follows:

(1) Section 4106 is amended by—

(A) inserting “rate of basic” after “minimum” in the second sentence of subsection (c); and

(B) striking out “level and salary” and “and salary” and inserting in lieu thereof “and annual rate of basic pay” each place those words appear in subsection (e).

(2) Section 4107 is amended by—

(A) striking out “per annum full-pay scale or ranges” and inserting in lieu thereof “annual rates or ranges of rates of basic pay” in subsection (a);

(B) striking out “per annum full-pay ranges” and inserting in lieu thereof “annual ranges of rates of basic pay” the first sentence of in subsection (b) (1);

(C) inserting “facility” after “domiciliary” each place it appears in subsection (c); and

(D) amending subsection (e) by—

(i) striking out “basic compensation” and inserting in lieu thereof “rate of basic pay” in paragraph (1);

(ii) striking out “basic hourly rate” and “basic hourly rate of pay” and inserting in lieu thereof “hourly rate of basic pay” in paragraphs (2), (3), (5), (6), and (7);

(iii) striking out “compensation” each time it appears in paragraphs (1), (2), (3), (6), and (9) and inserting in lieu thereof “pay”;

(iv) amending the first sentence of paragraph (4) to read as follows: “A nurse performing service on a holiday designated by Federal statute or Executive order shall receive for each hour of such service the nurse’s hourly rate of basic pay, plus additional pay at a rate equal to such hourly rate of basic pay, for that holiday service, including overtime service.”; and

(v) striking out “compensated” and inserting in lieu thereof “paid” in paragraph (8).

(3) Subsection (a) of section 4112 is amended by striking out “compensation” and inserting in lieu thereof “pay” in the last sentence of such subsection.

(c) Chapter 73 of title 38, United States Code, is further amended as follows:

(1) Section 4103 is amended by—

(A) striking out “individuals” and inserting in lieu thereof “persons” in the second sentence of subsection (a) (4);

(B) striking out “and employees” in subsection (a) (8); and

(C) striking out “An individual” and inserting in lieu thereof “A person” in the second sentence of subsection (c).

(2) Subsection (a) of section 4105 is amended by striking out “employees” and inserting in lieu thereof “personnel” in clause (7).

(3) Section 4107 is amended by—

(A) striking out “individual” and inserting in lieu thereof “person” in the first sentence of subsection (c);

(B) striking out “employee’s” and inserting in lieu thereof “nurse’s”, and striking out “work” and inserting in lieu thereof “service”, in paragraph (2) of subsection (e); and

(C) striking out “duty” and inserting in lieu thereof “service” in paragraph (7) of subsection (e).

(4) Clause (1) of subsection (a) of section 4108 is amended by striking out “individual” and inserting in lieu thereof “person”.

(5) Section 4113 is amended by—

(A) striking out “of employees” and inserting in lieu thereof a comma and “of persons”; and

(B) striking out “paragraph (1) of section 4104” and inserting in lieu thereof “section 4104(1)”,.

(6) Subsection (d) (2) of section 4114 is amended by striking out “individual” and inserting in lieu thereof “person”.

(7) Subsection of section 4122 is amended by striking out “individuals” each time it appears and inserting in lieu thereof “persons”.

SEC. 310. (a) Chapter 17 of title 38, United States Code, is amended as follows:

(1) Section 610 is amended by—

(A) striking out “he” and inserting in lieu thereof “the Administrator” in the first sentence of subsection (a);

(B) striking out "he" and inserting in lieu thereof "such veteran" in subsections (a) (1) (B), (b) (2), and (c) ; and

(C) striking out "he" and inserting in lieu thereof "such person" in subsection (b) (1).

(2) Section 611 is amended by—

(A) striking out "him" and inserting in lieu thereof "the Administrator" in subsection (a) ; and

(B) striking out "he" and "him" each place those words appear in subsection (b) and inserting in lieu thereof "the Administrator";

(3) Section 612 is amended by—

(A) striking out "he" and inserting in lieu thereof "the Administrator" in the first sentence of subsection (a) ;

(B) striking out "him" and "he" each place those words appear in subsection (d) and inserting in lieu thereof "the Administrator";

(C) striking out "he" and inserting in lieu thereof "the Administrator" in subsection (g) ; and

(D) striking out "his" each place it appears in the second sentence of subsection (h) and inserting in lieu thereof "such veteran's".

(4) Section 613 is amended by—

(A) striking out "he" and inserting in lieu thereof "the Secretary" in subsection (b) (1) ; and

(B) striking out "he" each place it appears and inserting in lieu thereof "the Administrator" in subsection (b) (2).

(5) Section 614 is amended by—

(A) striking out "his" and inserting in lieu thereof "such veteran's" in subsection (a) ; and

(B) striking out "he" in subsection (b).

(6) Section 619 is amended by striking out "him" and inserting in lieu thereof "such veteran".

(7) The first sentence of subsection (b) of section 620 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

(8) Paragraphs (1) and (3) of section 621 are amended by striking out "he" each place it appears and inserting in lieu thereof "the Administrator".

(9) Subsection (b) of section 622 is amended by striking out "his" and inserting in lieu thereof "such veteran's".

(10) Section 623 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

(11) The first sentence of subsection (c) of section 624 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

(12) Section 626 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

(13) Subsection (a) of section 628 is amended by—

(A) striking out "he" and inserting in lieu thereof "the Administrator" in the first sentence of such subsection ; and

(B) striking out "his" and inserting in lieu thereof "such veteran's" in paragraph (2) (D) (ii) of such subsection.

(14) The second sentence of subsection (d) of section 632 is amended by striking out "him" and inserting in lieu thereof "the Administrator".

(15) Section 633 is amended by striking out "he" and inserting in lieu thereof "the President", and by striking out "his".

(16) Subsection (a) of section 642 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

(b) Section 3301 of title 38, United States Code, is amended by—

(1) striking out "his" and inserting "of a claimant" after "representative" and by striking out "himself" and inserting in lieu thereof "the claimant" in subsection (b) (1) ;

(2) striking out "in his" and inserting in lieu thereof "as a matter of" in subsection (d) ; and

(3) striking out "his" and inserting in lieu thereof "the Administrator's" in subsection (e).

(c) Chapter 73 of title 38, United States Code, is amended as follows :

(1) Section 4101 is amended by—

(A) striking out "servicemen" and inserting in lieu thereof "members of the armed forces" in subsection (b) ; and

(B) striking out "his" and "he" and inserting in lieu thereof "the Ad-

ministrator's" and "the Administrator", respectively, in subsection (d) (2) (as redesignated by section 305(a) (3) of this Act).

(2) Section 4103 is amended by—

(A) striking out the period at the end of the first sentence and inserting in lieu thereof a comma, and striking out "He" in the second sentence and inserting in lieu thereof "and who", in paragraphs (1), (2), and (3) of subsection (a); and

(B) striking out "his" and "he" and inserting in lieu thereof "such person's" and "such person", respectively, in the third sentence of subsection (c).

(3) Section 4104 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

(4) Section 4107 is amended by—

(A) striking out "he" each place it appears in subsection (b) (2) and inserting in lieu thereof "such person"; and

(B) striking out "he" and "his" and inserting in lieu thereof "such person" and "such person's", respectively, in subsection (c).

(5) Subsection (a) of section 4108 is amended by—

(A) striking out "his" and inserting in lieu thereof "such person's" in clause (2);

(B) striking out "him" and "his" and inserting in lieu thereof "such person" and "such person's", respectively in clause (3);

(C) striking out "him" and "his" and inserting in lieu thereof "such person" and "such person's", respectively, in clause (4);

(D) striking out "his" each place it appears and "him" in clause (5) and inserting in lieu thereof "such person's" and "such person", respectively; and

(E) striking out "his" each place it appears and inserting in lieu thereof "such person's" in clause (6).

(6) The first sentence of subsection (b) of section 4112 is amended by striking out "he" and inserting in lieu thereof "the Administrator".

(7) Section 4114 is amended by—

(A) striking out "he" each place it appears in the third and fifth sentences in subsection (b) (4) (as redesignated by section 112(a) (3) of this Act) and inserting in lieu thereof "such recipient";

(B) striking out "he" and "his" each place those words appear in the last sentence of subsection (b) (4) (as so redesignated) and inserting in lieu thereof "such person" and "such person's", respectively;

(C) striking out "he" and inserting in lieu thereof "the person" in subsection (d) (1); and

(D) striking out "his" and "he" and inserting in lieu thereof "such person" and "the person", respectively, in subsection (d) (2).

(8) Section 4116 is amended by—

(A) striking out "his" each place it appears in subsection (a) and inserting in lieu thereof "such person's";

(B) striking out "his" and "him" and inserting in lieu thereof "such person's" and "such person", respectively, in subsection (b);

(C) striking out "his" each place it appears in subsection (c) and inserting in lieu thereof "such person's"; and

(D) striking out "he" and "his" each place those words appear in subsection (e) and inserting in lieu thereof "the Administrator" and "such person's", respectively.

(9) Subsection (a) of section 4121 is amended by striking out "his" and "he" each place those words appear and inserting in lieu thereof "the Administrator's" and "the Administrator", respectively.

(10) Section 4122 is amended by striking out "he" and inserting in lieu thereof "the Chief Medical Director" in subsections (b) and (c).

(d) Chapter 75 of title 38, United States Code, is amended by striking out "he" each place it appears in clauses (3), (9), (10), and (11) of section 4202 and inserting in lieu thereof "the Administrator".

(e) Chapter 81 of title 38, United States Code, is amended as follows:

(1) Subsection (b) of section 5001 is amended by striking out "him" and "his" and inserting in lieu thereof "the Administrator" and "the Chief Medical Director's", respectively.

- (2) Section 5002 is amended by—
 (A) striking out “he” each place it appears and inserting in lieu thereof “the President”; and
 (B) striking out “his opinion” and inserting in lieu thereof “the opinion of the President such is”.
- (3) Paragraphs (2) and (3) of subsection (b) of section 5004 are amended by striking out “he” and inserting in lieu thereof “the Administrator”.
- (4) The second sentence of section 5005 is amended by striking out “He” and inserting in lieu thereof “The President”.
- (5) The first sentence of section 5007 is amended by striking out “his” and inserting in lieu thereof “the Administrator’s”.
- (6) Subsection (c) of section 5011 is amended by striking out “him” and inserting in lieu thereof “the Administrator”.
- (7) Section 5012 is amended by—
 (A) striking out “his” in the first and fourth sentences of subsection (a) and inserting in lieu thereof “the Administrator’s”;
 (B) striking out “he” and inserting in lieu thereof “the Administrator” in subsection (b); and
 (C) striking out “him” and inserting in lieu thereof “the Administrator” in subsection (c).
- (8) Section 5013 is amended by striking out “he” and inserting in lieu thereof “the Administrator”.
- (9) Section 5014 is amended by—
 (A) striking out “he” each place it appears in the first and fourth sentences and inserting in lieu thereof “the Administrator”; and
 (B) striking out “his” in the first sentence and inserting in lieu thereof “the Administrator’s”.
- (10) Subsection (b) of section 5035 is amended by striking out “he” and inserting in lieu thereof “the Administrator”.
- (11) The first sentence of subsection (a) of section 5053 is amended by striking out “he” and inserting in lieu thereof “the Administrator”.
- (12) The second sentence of subsection (b) of section 5054 is amended by striking out “he” and inserting in lieu thereof “the Administrator”.
- (13) The first sentence of subsection (a) of section 5055 is amended by striking out “him” and inserting in lieu thereof “the Administrator”.
- (f) Chapter 82 of title 38, United States Code, is amended as follows:
 (1) The second sentence of subsection (f) (as redesignated by section 121(1) of this Act) of section 5070 is amended by striking out “he” and inserting in lieu thereof “the Administrator”.
- (2) Section 5071 is amended by striking out “he” and inserting in lieu thereof “the Administrator”.
- (3) Section 5073 is amended by—
 (A) striking out “he” each place it appears in subsection (b) and inserting in lieu thereof “the Administrator”; and
 (B) striking out “he” each place it appears in subsection (c) and inserting in lieu thereof “the Administrator”.
- (4) Subsection (b) of section 5083 is amended by striking out “his” in the language preceding clause (1) and in clause (4) and inserting in lieu thereof “the Administrator’s”.
- (5) Subsection (b) of section 5093 is amended by striking out “his” in the language preceding clause (1) and in clause (4) and inserting in lieu thereof “the Administrator’s”.
- (6) Section 5096 is amended by striking out “he” and inserting in lieu thereof “the Administrator”.
- SEC. 311. Except as otherwise provided in this Act, the amendments made by this Act to title 38, United States Code, shall become effective on October 1, 1976, or on the date of enactment, whichever is later.

INTRODUCTION

S. 2908, the proposed Veterans Omnibus Health Care Act of 1976, represents the culmination of 2 years of planning, development, and consideration by the Committee on Veterans' Affairs and its Sub-

committee on Health and Hospitals. S. 2908 was introduced on February 2, 1976. The Subcommittee conducted 2 days of hearings on S. 2908 and related legislation on February 18 and 19, 1976. Submitting testimony to the Subcommittee at that time were Chief Medical Director John D. Chase and other representatives of the Veterans' Administration's Department of Medicine and Surgery, and representatives of veterans' organizations, professional groups, labor unions, and other concerned parties.

In executive session on May 25, 1976, the Subcommittee considered and unanimously ordered S. 2908 favorably reported to the full Committee, with an amendment in the nature of a substitute. The Committee on Veterans' Affairs in executive session on June 16, 1976, approved one amendment of a substantive and technical nature to the committee substitute amendment, and unanimously voted to report favorably S. 2908 as reported from the Subcommittee.

SUMMARY OF S. 2908, AS REPORTED

Basic Purpose

The basic purpose of S. 2908, as reported, is to improve, in two fundamental ways, the quality and efficiency of health care provided to ill or disabled veterans in the Veterans' Administration's health care system.

First, the Committee bill is designed to shape a new direction in veterans health care by taking steps to control the growth in the VA medical and hospital program and to emphasize improved and more comprehensive treatment, through the refocusing of existing resources, for veterans suffering from service-connected disabilities. The growth in expenditures for outpatient care, beneficiary travel, and other medical and hospital benefits during the past decade has primarily benefited veterans with non-service-connected disabilities. The Committee bill represents a return to the basic principle on which the VA system of hospitals and health care facilities was founded—that veterans suffering from disabilities incurred during periods of military service to this country should have first call on Federal health care services and should receive priority attention in the VA system.

Second, the Committee bill is designed to establish important new medical programs primarily for the treatment of veterans with serious service-connected or service-related disabilities. These include (1) a pioneering, cost-effective program in preventive health care for seriously disabled service-connected veterans; (2) a comprehensive treatment and rehabilitation program for veterans suffering from alcoholism, drug dependence, or the effects of drug abuse; and (3) a program of readjustment professional counseling to assist recently-discharged veterans suffering from psycho-social readjustment problems.

Summary of Provisions

S. 2908 as reported has three titles: General substantive amendments; drug and alcohol treatment and rehabilitation amendments; and technical and conforming amendments.

Title I: *General Veterans Health Care and Department of Medicine and Surgery Amendments.*—This title contains general substantive

amendments to chapters 17, 73, 81, and 82 of title 38, United States Code. Included in title I of the bill are provisions that would:

1. Require periodic reexaminations of VA beneficiary travel reimbursement rates, and reduce expenditures for such travel by (a) requiring persons receiving care for non service-connected conditions, as a precondition for the receipt of travel reimbursement, to declare and certify their inability to defray the expenses of travel, and (b) generally limiting reimbursement to the cost of travel by public transportation.

2. Authorize limited mental health services (under specified circumstances), consultation, professional counseling, and training, on an outpatient basis, for the family members of a veteran who is receiving outpatient care, when essential to the effective treatment and rehabilitation of the veteran.

3. Establish a new program to provide outpatient readjustment professional counseling for veterans and, where indicated, followup mental health services for veterans (and their family members, when necessary) to assist with readjustment problems arising within 4 years of discharge, or 2 years after enactment, whichever is later.

4. Provide total VA health care benefits for any veteran with a service-connected disability rated at 50 percent or more—lowered from 80 percent under present law and expanded to include preventive health care in the nature of a health maintenance organization.

5. Establish a system of priorities for outpatient care stressing priority treatment for veterans requiring treatment for service-connected disabilities, those with less-than-50-percent-rated service-connected disabilities, those with 50-percent-or-more-rated service-connected disabilities, and those with major non service-connected disabilities.

6. Establish a new program in preventive health care for veterans being treated for service-connected disabilities and in connection with the treatment of veterans with service-connected disabilities rated at 50 percent or more, to commence on January 1, 1977; authorize the establishment of a small pilot program for other veterans with service-connected disabilities to demonstrate the medical advantages and cost-effectiveness of furnishing comprehensive, health maintenance, preventive health care services to veterans; and authorize, as part of national immunization programs administered by HEW, the VA to provide immunization against infectious diseases to veterans otherwise receiving treatment at VA health care facilities, and to process malpractice or negligence claims arising from such immunizations in accordance with regular VA procedures.

7. Provide statutory authorization for the Department of Medicine and Surgery's compensated work-therapy program by allowing for arrangements with private industry and non-profit corporations to supply work projects for patient-workers, with remuneration at rates of pay not less than those specified in the Fair Labor Standards Act (29 U.S.C. 201 et seq.), and by establishing a revolving fund to receive and disburse funds in connection with such work.

8. Make a series of changes in the VA's authority to provide outpatient care to veterans seeking treatment for non-service-connected disabilities, including provisions to limit non-service-connected outpatient care to care provided in VA facilities; to limit the duration of

outpatient care provided to veterans to complete treatment incident to hospital care; to limit the provision of outpatient care to "obviate" the need for hospital admission; and to permit followup outpatient dental services for the treatment of non-service-connected dental disabilities begun during hospitalization.

9. Permit the transfer of veterans who have received maximum hospital benefits to intermediate care facilities, at VA expense, and at lower rates of reimbursement than the rates authorized for nursing home care; increase permissible reimbursement rates for contract community nursing home care; and authorize discretionary direct admission to contract community nursing homes of veterans in need of nursing home care for non-service-connected disabilities, in accordance with the new statutory priorities for veterans with service-connected disabilities.

10. Clarify the authority to provide home health services (including certain home improvements and structural alterations) for veterans with service-connected or non-service-connected disabilities, as required for the effective and economical treatment of the disability, and limit expenditures for such purposes.

11. Provide a presumption of service connection, for treatment purposes only, for any disability which could be attributable to internment for more than 6 months as a prisoner of war.

12. Extend CHAMPVA coverage to the widow or surviving children of a veteran who, at the time of death, suffered from a total and permanent service-connected disability.

13. Authorize the acquisition and subsequent sale, assignment, or transfer of automobiles needed for special driver training courses in the VA's automobile and adaptive equipment program, and credit any proceeds therefrom to the applicable VA appropriation.

14. Shorten the probationary period for title 38 employees from 3 to 2 years, and establish statutory procedural protections to govern adverse or disciplinary and certain nondisciplinary actions with respect to all title 38 employees.

15. Extend until September 30, 1977, the VA's authority under Public Law 94-123 to pay special pay to physicians and dentists in the Department of Medicine and Surgery; and provide that clinical researchers who are otherwise eligible for special pay be entitled to receive special pay on the same terms and under the same conditions as other physicians and dentists in DM&S.

16. Assist in the recruitment and retention of nonphysician personnel by authorizing the VA to increase, on a nationwide basis, the minimum or maximum rates of basic pay for any category of title 5 health professional when such entry-grade pay adjustment is necessary for purposes of salary comparability, internal salary alignment, or staffing requirements.

17. Provide for the employment of optometrists and podiatrists under the title 38 personnel system, at rates of basic pay specified by statute in a new pay schedule in title 38.

18. Provide, in a new subchapter of chapter 73 of title 38 entitled "Protection of Patient Rights", standards for obtaining the informed

consent of all patients and research subjects, and provisions (generally incorporating existing provisions of law set forth elsewhere) to guarantee the confidentiality of certain patient medical records and proscribe discrimination against alcohol or drug abusers in admission to VA health care facilities.

19. Provide for improved efficiency in the budgeting, bookkeeping, and operations of the Veterans Canteen Service.

20. Require the VA, in accordance with present DM&S plans, to establish and operate a minimum of 10,000 nursing home care beds by fiscal year 1980.

21. Provide for mechanisms to improve coordination and communication with other Federal and community health care, quality assessment, financial reimbursement, and planning programs; and include "emergency room medical resources" (under specified circumstances) in the definition of "specialized medical resources" which may be the subject of sharing agreements under chapter 81 of title 38.

22. Encourage the construction of State home facilities in States which are not now served by VA residential health care facilities, and establish minimum quality standards for State veterans home facilities receiving financial support from the VA.

23. Require the Chief Medical Director to prepare a report on long-range adjustments that should be made in the VA health care program to accommodate the growing number of elderly veterans.

Title II: Veterans Drug and Alcohol Treatment and Rehabilitation Amendments.—This title provides for the establishment of comprehensive treatment and rehabilitation programs for veterans suffering from alcoholism or alcohol-related disabilities, drug dependence, or drug abuse. Included in title II are provisions that would:

1. Establish comprehensive programs for the treatment and rehabilitation of veterans suffering from alcohol- and drug-related disabilities, utilizing a broad range of treatment modalities and professional, paraprofessional, and lay personnel.

2. Provide authority to establish and contract with half-way houses for the rehabilitation of veterans with alcohol or drug abuse problems.

3. Authorize the treatment, at VA expense, of a veteran who suffers from, and who has a close family member who suffers from, an alcohol or drug abuse problem, in a community facility where both the veteran and (not at VA expense) the family member can receive treatment together.

4. Make eligible for comprehensive drug abuse treatment and rehabilitation veterans with undesirable discharges and (in most cases) bad conduct discharges, and facilitate the procedures under which veterans with less-than-honorable discharges can apply to have their discharges upgraded.

5. Require that the VA take affirmative steps to seek out veterans eligible for drug abuse treatment and rehabilitation, counsel such veterans with respect to their eligibility for special drug treatment programs, and increase employment and training opportunities for veterans who receive treatment for drug and alcohol problems in VA health care facilities.

6. Provide procedures for the treatment in VA facilities of active-duty service personnel suffering from drug dependence if placement in a VA facility is voluntarily requested during the last 30 days of active duty.

7. Require annual reports by the Administrator on the implementation of the new drug and alcohol treatment programs.

Title III: *Medical Technical and Conforming Amendments*.—Title III contains amendments of a technical, perfecting, or conforming nature. Included are provisions that would:

1. Consolidate and clarify the language authorizing biomedical, prosthetic, and health care services research.

2. Eliminate those remaining distinctions between peace-time and war-time military service, for purposes of eligibility for certain minor health care benefits, in order to conform to decisions made with respect to eligibility for hospital care, outpatient care, and nursing home care in the Veterans Health Care Expansion Act of 1973, Public Law 93-82.

3. Clarify the VA's authority to contract for hospital care and medical services with respect to treatment for the service-connected and non-service-connected disabilities of eligible veterans.

4. Change all references from "physician's assistants" or "physicians' assistants" in title 38 to "physician assistants", and change all references from "dentists' assistant" or "expanded-duty dental auxiliaries" to "expanded-function dental auxiliaries".

5. Change all references from "pay", "compensation", or "wages" to a standardized reference to "rate of basic pay".

6. Eliminate all pronouns and nouns which are discriminatory on the basis of gender—for example, change all references from "his" to "such person's", and so forth.

BACKGROUND

1976: A Critical Year for the VA Health Care System

The Committee is convinced that 1976 marks an important juncture in the history of the Department of Medicine and Surgery (DM&S).

Fourteen years ago, before the build-up of American troops in Southeast Asia, DM&S spent \$1.17 billion on medical programs, and employed 130,352 persons in medical and health care capacities. By 1969, after 6 war years, expenditures for medical programs had risen less than \$400 million, to \$1.55 billion, and only 1,345 additional employees had been added to the Department's rolls—and this despite a war producing high casualty rates and far more veterans with chronic and permanent injuries than the Korean conflict.

It was clear in 1969 that the ability of the VA hospital system to cope with the demands of veterans of the Vietnam era would be seriously compromised without a substantial infusion of money and personnel to improve the comprehensiveness and the quality of care available in VA health care facilities. Congress therefore embarked on a 7-year period of providing for the sustained growth of the VA health care system. From fiscal year 1969 to 1976, DM&S's health care

appropriations tripled (see table 1), and 50,000 new health care personnel were added (see table 2). Today, the VA health care system has virtually caught up with the demands of the Indochina War era, and has made the difficult transition from wartime to peacetime after the longest involvement of the United States in a war during the twentieth century.

With that task largely completed, the VA health care system now confronts a new series of challenges. The rapid growth in funding and beneficiaries over the past 7 years has generated substantial administrative problems and raised questions about the VA's physical capacity to provide quality care to the enormous number of newly-eligible veterans. Furthermore, with inflation eroding the purchasing power of the Federal dollar and with the new and increasingly important imperative of keeping overall Federal expenditures within Congressionally-established targets and limits, continued substantial growth in VA health care appropriations is no longer as feasible as it was 7 years ago.

The Committee believes that in 1976 Congressional efforts should concentrate on consolidating the impressive growth that has already occurred and ensuring the efficient utilization of resources that already exist. It is time to take a searching look at present priorities within this enormous system of hospitals, outpatient clinics, and other facilities, and, where necessary, to establish clear priorities for the allocation of VA resources in order to redirect care and expenditures for the benefit of veterans with the strongest claim to treatment in VA health care facilities.

TABLE 1.—*Appropriated amounts for Department of Medicine and Surgery medical programs, fiscal years 1960-77*

Fiscal year:	[In billions of dollars]	Appropriated amount
1960		\$0. 950
1961		1. 067
1962		1. 110
1963		1. 170
1964		1. 217
1965		1. 306
1966		1. 358
1967		1. 409
1968		1. 479
1969		1. 551
1970		1. 835
1971		2. 095
1972		2. 495
1973		2. 922
1974		3. 105
1975		3. 771
1976		4. 546
1977		4. 904

Source: Figures supplied by the Department of Medicine and Surgery.

TABLE 2.—Average employment, Department of Medicine and Surgery medical programs, fiscal years 1960-77

Fiscal year:	Average employment
1960	132, 730
1961	134, 263
1962	137, 600
1963	137, 064
1964	136, 670
1965	136, 217
1966	135, 200
1967	137, 419
1968	140, 364
1969	138, 750
1970	137, 934
1971	141, 201
1972	152, 271
1973	160, 476
1974	165, 293
1975	172, 675
1976 ¹	181, 734
1977 ¹	183, 870

¹ Estimated.

Source: Figures supplied by the Department of Medicine and Surgery.

Growth in Expenditures for Non-Service-Connected Care

The expanded capacity of the VA health care system during the past 7 years and the concomitant liberalization of eligibility requirements for inpatient care and outpatient services over the same period have primarily benefited veterans whose disabilities are non-service-connected. The most dramatic example of the increase in expenditures for non-service-connected care has occurred in the provision of outpatient services. In fiscal year 1970, the VA expended \$162,150,000 on outpatient staff visits, more than 60 percent of which supported care for service-connected veterans. By fiscal year 1976, expenditures for outpatient staff visits had more than tripled, to \$501,132,000, and the proportion of that sum spent on service-connected disabilities had dropped to 44 percent. In other words, the VA increased its expenditures on outpatient staff services by \$338,982,000 in 6 years; almost two-thirds of this increase went to the treatment of non-service-connected disabilities. (See table 3.)

TABLE 3.—OUTPATIENT MEDICAL PROGRAMS, VISITS, AND COSTS: FISCAL YEARS 1970-76

	Visits to VA staff and on a fee for service			Visits to VA staff			Visits on a fee for service basis		
	Total	SC ²	NSC ²	Total	SC ²	NSC ²	Total	SC ²	NSC ²
All purposes:									
Visits	6,968,878	4,504,712	2,464,166	5,792,617	3,352,504	2,440,113	1,176,261	1,152,208	24,053
Costs (in thousands)	\$190,032	\$127,166	\$62,866	\$162,150	\$99,742	\$62,408	\$27,882	\$27,424	\$458
Cost per visit	\$27.27			\$27.99			\$23.70		
Compensation and pension:									
Visits	390,100	230,159	159,941	336,383	198,466	137,917	53,717	31,693	22,024
Costs (in thousands)	\$19,139	\$11,292	\$7,874	\$18,109	\$10,684	\$7,425	\$1,030	\$608	\$422
Cost per visit	\$49.06			\$53.83			\$19.17		
Outpatient treatment-S.C.:									
Visits	3,573,133	3,573,133		2,456,658	2,456,658		1,116,475	1,116,475	
Costs (in thousands)	\$101,823	\$101,823		\$75,088	\$75,088		\$26,735	\$26,735	
Cost per visit	\$28.50			\$30.57			\$23.95		
10-10, applications for care:									
Visits	1,222,591	529,382	693,209	1,221,124	528,747	692,377	1,467	635	832
Costs (in thousands)	\$19,790	\$8,570	\$11,220	\$19,768	\$8,560	\$11,208	\$22	\$10	\$12
Cost per visit	\$16.19			\$16.19			\$15.00		
Prebed care:									
Visits	109,035		109,035	109,035		109,035			
Costs (in thousands)	\$3,350		\$3,350	\$3,350		\$3,350			
Cost per visit	\$30.27			\$30.72					
Ambulatory care:									
Visits									
Costs (in thousands)									
Cost per visit									
Outpatient treatment-NSC:									
Visits	1,374,564		1,374,564	1,374,564		1,374,564			
Costs (in thousands)	\$36,376		\$36,376	\$36,376		\$37,376			
Cost per visit	\$26.46			\$26.46					
Aid and attendance, and household:									
Visits	7,815	1,938	5,877	6,306	1,564	4,742	1,509	374	1,135
Costs (in thousands)	\$233	\$58	\$175	\$202	\$50	\$152	\$31	\$8	\$23
Cost per visit	\$29.81			\$32.03			\$20.54		

See footnotes at end of table, p. 70.

TABLE 3.—OUTPATIENT MEDICAL PROGRAMS, VISITS, AND COSTS¹ FISCAL YEARS 1970-76—Continued

	Visits to VA staff and on a fee for service			Visits to VA staff			Visits on a fee for service basis		
	Total	SC ²	NSC ²	Total	SC ²	NSC ²	Total	SC ²	NSC ²
FISCAL YEAR 1971									
All other: ⁴									
Visits	291,640	170,100	121,540	288,547	167,069	121,478	3,093	3,031	62
Costs (in thousands)	\$9,321	\$5,423	\$3,898	\$9,257	\$5,360	\$3,897	\$64	\$63	\$1
Cost per visit	\$31.96			\$32.08			\$20.69		
All purposes:									
Visits	7,711,798	4,893,347	2,818,451	6,445,852	3,667,746	2,778,106	1,265,946	1,225,601	40,345
Costs (in thousands)	\$224,607	\$147,014	\$77,593	\$191,375	\$114,501	\$76,874	\$33,232	\$32,513	\$719
Cost per visit	\$29.12			\$29.68			\$26.25		
Compensation and pension:									
Visits	456,302	269,218	187,084	369,911	218,247	151,664	86,391	50,971	35,420
Costs (in thousands)	\$21,822	\$12,672	\$9,150	\$20,266	\$11,754	\$8,512	\$1,556	\$918	\$638
Cost per visit	\$47.82			\$54.78			\$18.01		
Outpatient treatment-SC:									
Visits	3,857,659	3,857,659		2,668,262	2,688,262		1,169,397	1,169,397	
Costs (in thousands)	\$117,432	\$117,432		\$95,923	\$95,923		\$31,509	\$31,509	
Cost per visit	\$30.44			\$35.96			\$26.94		
10-10, applications for care:									
Visits	1,373,668	594,668	778,700	1,371,340	593,790	777,550	2,028	878	1,150
Costs (in thousands)	\$24,144	\$10,381	\$13,763	\$24,122	\$10,372	\$13,750	\$222	\$9	\$13
Cost per visit	\$17.58			\$17.59			\$10.84		
Prepaid care:									
Visits	114,629		114,629	114,629		114,629			
Costs (in thousands)	\$3,596		\$3,596	\$3,596		\$3,596			
Cost per visit	\$31.37			\$31.37					
Ambulatory care:									
Visits									
Costs (in thousands)									
Cost per visit									
Outpatient treatment-NSC:									
Visits	1,595,452		1,595,452	1,595,452		1,595,452			
Costs (in thousands)	\$45,469		\$45,469	\$45,469		\$45,469			
Cost per visit	\$28.49			\$28.49					
Aid and attendance, and housebound:									
Visits	26,111	6,476	19,635	21,229	5,265	15,964	4,882	1,211	1,671
Costs (in thousands)	\$921	\$221	\$700	\$834	\$200	\$634	\$87	\$21	\$66
Cost per visit	\$35.27			\$39.28			\$17.82		

All other: ⁴									
Visits	288,277	165,326	122,951	285,092	162,182	122,847	3,248	3,144	104
Costs (in thousands)	\$11,223	\$6,308	\$4,915	\$11,165	\$6,252	\$4,913	\$58	\$56	\$2
Cost per visit	\$38.93			\$39.17			\$17.85		
FISCAL YEAR 1972									
All purposes:									
Visits	9,148,286	5,353,619	3,794,667	7,551,485	3,904,558	3,646,927	1,596,801	1,449,061	147,740
Costs (in thousands)	\$276,976	\$171,443	\$105,533	\$235,969	\$133,815	\$102,154	\$41,007	\$37,628	\$3,379
Cost per visit	\$30.28			\$31.25			\$25.68		
Compensation and pension:									
Visits	406,065	239,579	166,486	342,035	201,801	140,234	64,030	37,778	26,252
Costs (in thousands)	\$23,065	\$13,609	\$9,456	\$21,762	\$12,840	\$8,922	\$1,303	\$769	\$534
Cost per visit	\$56.80			\$63.63			\$20.35		
Outpatient treatment-SC:									
Visits	4,258,093	4,258,093		2,891,602	2,891,602		1,366,491	1,366,491	
Costs (in thousands)	\$137,131	\$137,131		\$101,315	\$101,315		\$35,816	\$35,816	
Cost per visit	\$32.20			\$35.04			\$26.21		
10-10, applications for care:									
Visits	1,494,491	647,114	847,377	1,492,548	646,273	846,275	1,943	841	1,102
Costs (in thousands)	\$27,882	\$12,073	\$15,809	\$27,862	\$12,064	\$15,798	\$20	\$9	\$11
Cost per visit	\$18.66			\$18.67			\$10.29		
Prebed care:									
Visits	318,536		318,536	318,536		318,536			
Costs (in thousands)	\$7,293		\$7,293	\$7,293		\$7,293			
Cost per visit	\$22.90			\$22.90					
Ambulatory care:									
Visits									
Costs (in thousands)									
Cost per visit									
Outpatient treatment-NSC:									
Visits	2,156,425		2,156,425	2,156,425		2,156,425			
Costs (in thousands)	\$61,597		\$61,597	\$61,597		\$61,597			
Cost per visit	\$28.56			\$28.56					
Aid and attendance, and household:									
Visits	219,871	54,528	165,343	60,383	14,975	45,408	159,488	39,553	119,935
Costs (in thousands)	\$6,536	\$1,621	\$4,915	\$2,782	\$690	\$2,092	\$3,754	\$931	\$2,823
Cost per visit	\$29.72			\$46.07			\$23.53		
All other: ⁴									
Visits	294,805	154,305	140,500	289,956	149,907	140,049	4,849	4,398	451
Costs (in thousands)	\$13,472	\$7,009	\$6,463	\$13,356	\$6,906	\$6,452	\$114	\$103	\$11
Cost per visit	\$45.69			\$46.07			\$23.51		

See footnotes at end of table, p. 70.

TABLE 3.—OUTPATIENT MEDICAL PROGRAMS, VISITS, AND COSTS: FISCAL YEARS 1970-76—Continued

	Visits to VA staff and on a fee for service				Visits to VA staff				Visits on a fee for service basis			
	Total		NSC ²		Total		SC ²		Total		SC ²	
	NSC ²	SC ²	NSC ²	SC ²	NSC ²	SC ²	NSC ²	SC ²	NSC ²	SC ²	NSC ²	SC ²
FISCAL YEAR 1973												
All purposes:												
Visits:	10,463,494	5,477,450	4,986,044		8,770,097	4,026,794	4,743,303		1,693,397	1,450,656	242,741	
Costs (in thousands):	\$324,785	\$188,088	\$136,697		\$278,079	\$148,447	\$129,632		\$46,706	\$39,641	\$7,065	
Cost per visit:	\$31.04				\$31.71				\$27.58			
Compensation and pension:												
Visits:	339,557	200,339	139,218		310,686	183,305	127,381		28,871	17,034	11,837	
Costs (in thousands):	\$23,278	\$13,733	\$9,545		\$22,382	\$13,205	\$9,177		\$896	\$528	\$368	
Cost per visit:	\$68.55				\$72.04				\$31.03			
Outpatient treatment-SC:												
Visits:	4,355,368	4,355,368			2,997,053	2,997,053			1,358,315	1,358,315		
Costs (in thousands):	\$151,649	\$151,649			\$113,260	\$113,260			\$38,389	\$38,389		
Cost per visit:	\$34.81				\$37.79				\$28.26			
10-10, applications for care:												
Visits:	1,577,282	682,963	894,319		1,576,143	682,470	893,673		1,139	493	646	
Costs (in thousands):	\$34,305	\$14,854	\$19,451		\$34,284	\$14,845	\$19,439		\$21	\$9	\$12	
Cost per visit:	\$21.75				\$21.75				\$18.44			
Prebed care:												
Visits:	611,969		611,969		611,969		611,969					
Costs (in thousands):	\$12,027		\$12,027		\$12,027		\$12,027					
Cost per visit:	\$19.65				\$19.65							
Ambulatory care:												
Visits:												
Costs (in thousands):												
Cost per visit:												
Outpatient treatment-NSC:												
Visits:	2,894,062		2,894,062		2,879,739		2,879,739		14,323		14,323	
Costs (in thousands):	\$79,087		\$79,087		\$78,953		\$78,953		\$134		\$134	
Cost per visit:	\$26.50				\$27.42				\$9.36			
Aid and attendance, and household:												
Visits:	367,417	91,119	276,298		81,101	20,113	60,988		286,316	71,006	215,310	
Costs (in thousands):	\$10,685	\$1,495	\$9,190		\$3,530	\$875	\$2,655		\$7,155	\$620	\$6,535	
Cost per visit:	\$29.08				\$43.53				\$24.99			
All other: ⁴												
Visits:	317,839	147,661	170,178		313,406	143,653	169,753		4,433	3,808	625	
Costs (in thousands):	\$13,754	\$6,357	\$7,397		\$13,643	\$6,262	\$7,381		\$111	\$95	\$16	
Cost per visit:	\$43.27				\$43.53				\$24.99			

FISCAL YEAR 1974

All purposes:

Visits..... 11,613,296 5,656,731 9,804,650 4,154,747 5,649,903 1,808,646 1,501,984 306,662
 Costs (in thousands)..... \$371,418 \$201,515 \$315,090 \$154,036 \$161,054 \$56,328 \$47,479 \$8,849
 Cost per visit..... \$31.98 \$32.14 \$32.14

Compensations and pensions:

Visits..... 316,359 186,652 290,728 171,530 119,198 25,631 15,122 10,509
 Costs (in thousands)..... \$22,786 \$13,444 \$21,867 \$12,902 \$8,965 \$919 \$542 \$377
 Cost per visit..... \$72.03 \$75.21 \$75.21

Outpatient treatment-SC:

Visits..... 4,465,156 4,465,156 3,071,395 3,071,395 1,393,761 1,393,761 1,393,761 1,393,761
 Costs (in thousands)..... \$161,908 \$161,908 \$117,550 \$117,550 \$44,358 \$44,358 \$44,358 \$44,358
 Cost per visit..... \$36.26 \$38.27 \$38.27

10-10, applications for care:

Visits..... 1,692,876 733,015 959,861 732,504 959,191 1,181 511 670
 Costs (in thousands)..... \$38,514 \$16,676 \$21,838 \$16,667 \$21,826 \$21 \$9 \$12
 Cost per visit..... \$22.75 \$22.75 \$22.75

Pre-bed care:

Visits..... 772,018 772,018 772,918 772,918 772,018 772,018 772,018 772,018
 Costs (in thousands)..... \$23,228 \$23,228 \$23,228 \$23,228 \$23,228 \$23,228 \$23,228 \$23,228
 Cost per visit..... \$30.09 \$30.09 \$30.09

Ambulatory care:

Visits..... 3,539,740 3,539,740 3,539,740 3,539,740 3,539,740 3,539,740 3,539,740 3,539,740
 Costs (in thousands)..... \$96,654 \$96,654 \$96,654 \$96,654 \$96,654 \$96,654 \$96,654 \$96,654
 Cost per visit..... \$27.30 \$27.30 \$27.30

Outpatient treatment-NSC:

Visits..... 459,683 114,002 104,244 25,853 78,391 355,439 88,149 267,290
 Costs (in thousands)..... \$14,205 \$3,440 \$4,022 \$997 \$3,025 \$10,183 \$2,443 \$7,740
 Cost per visit..... \$30.90 \$30.90 \$38.58 \$38.58 \$38.58 \$28.65 \$28.65

Aid and attendance and household:

Visits..... 367,464 157,906 209,558 153,465 208,651 5,348 4,441 26
 Costs (in thousands)..... \$14,123 \$6,047 \$8,076 \$5,920 \$8,050 \$153 \$127 \$26
 Cost per visit..... \$38.43 \$38.43 \$38.58 \$38.58 \$38.58

All other:

Visits..... 13,943,022 6,251,273 11,909,019 4,592,158 7,316,861 2,034,003 1,659,115 347,888
 Costs (in thousands)..... \$463,865 \$231,974 \$393,053 \$173,447 \$219,606 \$70,812 \$58,527 \$12,285
 Cost per visit..... \$33.27 \$33.27 \$33.00 \$33.00 \$33.00 \$34.81 \$34.81

All purposes:

Visits..... 316,359 186,652 290,728 171,530 119,198 25,631 15,122 10,509
 Costs (in thousands)..... \$22,786 \$13,444 \$21,867 \$12,902 \$8,965 \$919 \$542 \$377
 Cost per visit..... \$72.03 \$75.21 \$75.21

Compensation and pension:

Visits..... 4,465,156 4,465,156 3,071,395 3,071,395 1,393,761 1,393,761 1,393,761 1,393,761
 Costs (in thousands)..... \$161,908 \$161,908 \$117,550 \$117,550 \$44,358 \$44,358 \$44,358 \$44,358
 Cost per visit..... \$36.26 \$38.27 \$38.27

10-10, applications for care:

Visits..... 1,692,876 733,015 959,861 732,504 959,191 1,181 511 670
 Costs (in thousands)..... \$38,514 \$16,676 \$21,838 \$16,667 \$21,826 \$21 \$9 \$12
 Cost per visit..... \$22.75 \$22.75 \$22.75

Pre-bed care:

Visits..... 772,018 772,018 772,918 772,918 772,018 772,018 772,018 772,018
 Costs (in thousands)..... \$23,228 \$23,228 \$23,228 \$23,228 \$23,228 \$23,228 \$23,228 \$23,228
 Cost per visit..... \$30.09 \$30.09 \$30.09

Ambulatory care:

Visits..... 3,539,740 3,539,740 3,539,740 3,539,740 3,539,740 3,539,740 3,539,740 3,539,740
 Costs (in thousands)..... \$96,654 \$96,654 \$96,654 \$96,654 \$96,654 \$96,654 \$96,654 \$96,654
 Cost per visit..... \$27.30 \$27.30 \$27.30

Outpatient treatment-NSC:

Visits..... 459,683 114,002 104,244 25,853 78,391 355,439 88,149 267,290
 Costs (in thousands)..... \$14,205 \$3,440 \$4,022 \$997 \$3,025 \$10,183 \$2,443 \$7,740
 Cost per visit..... \$30.90 \$30.90 \$38.58 \$38.58 \$38.58 \$28.65 \$28.65

Aid and attendance and household:

Visits..... 367,464 157,906 209,558 153,465 208,651 5,348 4,441 26
 Costs (in thousands)..... \$14,123 \$6,047 \$8,076 \$5,920 \$8,050 \$153 \$127 \$26
 Cost per visit..... \$38.43 \$38.43 \$38.58 \$38.58 \$38.58

All other:

Visits..... 13,943,022 6,251,273 11,909,019 4,592,158 7,316,861 2,034,003 1,659,115 347,888
 Costs (in thousands)..... \$463,865 \$231,974 \$393,053 \$173,447 \$219,606 \$70,812 \$58,527 \$12,285
 Cost per visit..... \$33.27 \$33.27 \$33.00 \$33.00 \$33.00 \$34.81 \$34.81

See footnotes at end of table, p. 70.

FISCAL YEAR 1975

FISCAL YEAR 1976 *

All purposes:

Visits	14,665,000	6,551,000	8,114,000	12,493,000	4,786,000	7,707,000	2,172,000	1,765,000	407,000
Costs (in thousands)	\$591,096	\$296,618	\$294,478	\$501,132	\$222,527	\$278,605	\$89,964	\$74,091	\$15,873
Cost per visit	\$40.30			\$40.11			\$41.41		

Compensation and pension:

Visits	355,000	209,000	146,000	235,000	192,000	133,000	30,000	17,000	13,000
Costs (in thousands)	\$31,231	\$18,415	\$12,816	\$29,780	\$17,593	\$12,187	\$1,451	\$822	\$629
Cost per visit	\$87.97			\$91.63			\$48.38		

Outpatient treatment—SC:

Visits	5,114,000	5,114,000		3,500,000	3,500,000		1,614,000	1,614,000	
Costs (in thousands)	\$237,026	\$237,026		\$168,980	\$168,980		\$68,056	\$68,046	
Cost per visit	\$46.34			\$48.28			\$42.16		

10-10, applications for care:

Visits	2,061,000	892,000	1,169,000	2,068,000	891,000	1,167,000	3,000	1,000	2,000
Costs (in thousands)	\$57,812	\$25,023	\$32,789	\$57,747	\$25,001	\$32,746	\$65	\$22	\$43
Cost per visit	\$28.05			\$28.06			\$21.67		

Prebed care:

Visits	15,000		15,000	15,000		15,000			
Costs (in thousands)	\$2,442		\$2,442	\$2,442		\$2,442			
Cost per visit	\$162.80			\$162.80					

Ambulatory care:

Visits	1,515,000		1,515,000	1,515,000		1,515,000			
Costs (in thousands)	\$53,161		\$53,161	\$53,161		\$53,161			
Cost per visit	\$35.90			\$35.09					

Outpatient treatment—MSC:

Visits	4,550,000		4,550,000	4,550,000		4,550,000			
Costs (in thousands)	\$159,550		\$159,550	\$157,725		\$157,725			
Cost per visit	\$35.06			\$35.05					

Aid and attendance, and housebound:

Visits	595,000	148,000	447,000	147,000	37,000	110,000	448,000	111,000	337,000
Costs (in thousands)	\$25,453	\$6,337	\$19,116	\$7,932	\$1,996	\$5,936	\$17,521	\$4,431	\$13,180
Cost per visit	\$42.77			\$33.96			\$39.11		

All other:

Visits	460,000	188,000	272,000	433,000	166,000	267,000	27,000	22,000	5,000
Costs (in thousands)	\$24,421	\$9,817	\$14,604	\$23,365	\$8,957	\$14,408	\$1,056	\$860	\$196
Cost per visit	\$53.08			\$53.96			\$39.11		

FISCAL YEAR 1977 *

All purposes:

Visits	14,828,000	6,684,000	8,144,000	12,456,000	4,767,000	7,689,000	2,372,000	1,917,000	455,000
Costs (in thousands)	\$673,705	\$347,758	\$325,947	\$544,390	\$241,770	\$302,620	\$129,315	\$105,988	\$23,327
Cost per visit	45.43			43.70			\$54.51		

Compensation and pension:

Visits	365,000	215,000	150,000	325,000	192,000	133,000	40,000	23,000	17,000
Costs (in thousands)	\$35,051	\$20,667	\$14,384	\$32,504	\$19,202	\$13,302	\$2,547	\$1,465	\$1,082
Cost per visit	\$96.03			\$100.01			\$63.69		

See footnotes at end of table, p. 70.

TABLE 3.—OUTPATIENT MEDICAL PROGRAMS, VISITS, AND COSTS: FISCAL YEARS 1970-76—Continued

	Visits to VA staff and on a fee for service			Visits to VA staff			Visits on a fee for service basis		
	Total	SC ²	NSC ²	Total	SC ²	NSC ²	Total	SC ²	NSC ²
FISCAL YEAR 1977 ^a —Continued									
Outpatient treatment—SC:									
Visits	5,257,000	5,257,000	—	3,500,000	3,500,000	—	1,757,000	1,757,000	—
Costs (in thousands)	\$281,964	\$281,964	—	\$184,450	\$184,450	—	\$97,514	\$97,514	—
Cost per visit	\$53.63			\$52.70			\$55.50		
10-10; applications for care:									
Visits	2,063,000	893,000	1,170,000	2,058,000	891,000	1,167,000	5,000	2,000	3,000
Costs (in thousands)	\$63,161	\$27,340	\$35,821	\$63,016	\$27,282	\$35,734	\$145	\$58	\$87
Cost per visit	\$30.61			\$30.62			\$29.00		
Prebed care:									
Visits	12,000	—	12,000	12,000	—	12,000	—	—	—
Costs (in thousands)	\$2,133	—	\$2,133	\$2,133	—	\$2,133	—	—	—
Cost per visit	\$177.75			\$177.75			—	—	—
Ambulatory care:									
Visits	1,518,000	—	1,518,000	1,518,000	—	1,518,000	—	—	—
Costs (in thousands)	\$58,139	—	\$58,139	\$58,139	—	\$58,139	—	—	—
Cost per visit	\$38.30			\$38.30			—	—	—
Outpatient treatment—NSC:									
Visits	4,570,000	—	4,570,000	4,500,000	—	4,500,000	70,000	—	70,000
Costs (in thousands)	\$175,534	—	\$175,534	\$172,170	—	\$172,170	\$3,364	—	\$3,364
Cost per visit	\$38.41			\$38.26			\$48.05	—	
Aid and attendance, housebound:									
Visits	655,000	162,000	493,000	175,000	43,000	132,000	480,000	119,000	361,000
Costs (in thousands)	\$35,021	\$8,659	\$26,362	\$10,306	\$2,532	\$7,774	\$24,715	\$6,127	\$18,583
Cost per visit	\$53.46			\$58.89			\$51.49		
All other: ⁴									
Visits	388,000	157,000	231,000	368,000	141,000	227,000	20,000	16,000	4,000
Costs (in thousands)	\$22,702	\$9,128	\$13,574	\$21,672	\$8,304	\$13,368	\$1,030	\$824	\$206
Cost per visit	\$58.51			\$58.89			\$51.49		

¹ Excludes visits and costs for employee health care; excludes costs of beneficiary travel.² Workload division between service connected and nonservice connected are estimated.³ This represents the 1st year of the 14-4 cost report; cost figures should be considered approximations.⁴ Includes visits and costs for insurance, research, nonbed care, day hospitals and miscellaneous purposes.⁵ On the basis of experience to date it appears that approximately 13,100,000 visits will be realized in fiscal year 1976 (excluding employee health).⁶ 1976 col. of 1977 congressional budget.

Source: Figures supplied by the Department of Medicine and Surgery.

In 1973, eligibility for outpatient care benefits was broadly expanded to permit the treatment of any veteran suffering from a non-service-connected disability for whom outpatient treatment would "obviate the need" for hospital admission. (38 U.S.C. 612(f) (1) (A), as added by section 103(a) of Pub. L. 93-82). This significant liberalization led to the sudden surge in the number of non-service-connected outpatient staff visits between 1973 and 1976. In fiscal year 1973, the year before enactment of the liberalizing "obviate" clause, there were 3,491,635 outpatient staff visits for the treatment of non-service-connected disabilities. By fiscal year 1975, the first full year after enactment of the new law, the number of such visits had jumped to 5,728,316, an increase of more than 64 percent in 2 years. There were 1,365,827 "obviate" visits that year, accounting for roughly one-quarter of all non-service-connected visits and almost two-thirds of the increase over 1973.

The result of the enormous increase in the number of outpatient visits during the last 3 years has been serious overcrowding and long waiting lines at virtually every outpatient facility in the VA health care system. The Committee is concerned that, in its laudable efforts to cope under trying physical circumstances with the growing demand for outpatient services, the VA has not been sufficiently sensitive to the special needs of veterans seeking treatment for service-connected conditions. In many respects, service-connected care has suffered as the amount and proportion of resources devoted to the care of veterans with non-service-connected conditions has increased substantially.

Although this is particularly true of outpatient services, it is also true in many other areas of the VA medical program where the level of expenditures for non-service-connected veterans has all but overwhelmed the level for the service-connected. Expenditures for inpatient hospital care, beneficiary travel to and from VA health care facilities, placement of veterans in VA and community nursing homes, home health services, and many other medical and medically-related programs have grown substantially over the amounts expended a half-decade ago, and in each instance the better part of the increase has gone to veterans with non-service-connected conditions.

The VA hospital system, since its establishment more than 50 years ago, has had as its primary mission the provision of first-class medical care to service-connected veterans. Its secondary mission has been to provide care for non-service-connected veterans, but only to the extent that facilities are available so as to bring about a patient population size which would promote efficient utilization of resources. As funding for the VA's medical program grows increasingly tight, it is imperative that funds be spent first for the benefit of those with the strongest claim to treatment. Service-connected veterans should not be forced to compete with non-service-connected veterans for scarce VA medical resources. The principal purpose of S. 2908, as reported, is to redirect care and expenditures to the system's primary beneficiaries—veterans with service-connected disabilities—so as to ensure that their health care needs are met first.

DISCUSSION

REORDERING HEALTH CARE PRIORITIES TO STRESS THE NEEDS OF
VETERANS WITH SERVICE-CONNECTED DISABILITIES*Statutory Outpatient Care Priorities*

On January 5, 1976, the Deputy Chief Medical Director of the Department of Medicine and Surgery distributed a circular (No. 10-76-2) entitled "Identification of Records of Veterans Who Have a Service-Connected Disability." The first paragraphs of the circular stated, in pertinent part:

Prompt attention to providing care to all veterans is a goal that we continually strive to meet. It is recognized, however, that because of limited facilities there are instances during peak workload hours that require the establishment of priorities. The service-connected veteran has, historically and factually, been considered as being entitled to the first priority for care when it has been necessary to formalize procedures.

It has been brought to our attention during recent months that too often under the patient care workload we manage today, we fail to properly identify those veterans with service-connected disabilities so that priority attention may be provided to them.

On August 3, 1976, over a month after this bill was ordered reported, the Chief Medical Director went considerably further by prescribing Interim Issue 10-76-21 to amend the DM&S manual to establish "Priorities for Admission to Outpatient Treatment". This document is reprinted in the Appendices to this report. The priorities established in this new DM&S regulation in many respects derive from the priorities which were first proposed in S. 2908 as introduced on February 2 and as reported.

To assist DM&S with this important task of facilitating outpatient treatment for service-connected veterans, several provisions in the Committee bill are designed to ensure that funds for outpatient care are spent first for the benefit of veterans with service-connected disabilities and, then, as funds and facilities are available, for other veterans in need of such care.

One of the most important of these provisions is contained in section 104 (a) (9) of the Committee bill. This provision would add a new subsection (i) to section 612 of title 38, in order to establish—for the first time—a statutory hierarchy of priorities for outpatient medical care eligibility. Veterans seeking treatment for a service-connected disability would be accorded the highest priority. Next priority would go to veterans with service-connected disabilities rated at 50 percent or more. Third on the priority list would be veterans with service-connected disabilities rated at less than 50 percent and veterans eligible for outpatient mental health services as the result of initial readjustment counseling under section 612A of title 38 (as added by section 105 of the Committee bill). Fourth in priority would be veterans with permanent catastrophic injuries who receive an aid and attendance or

permanently housebound allowance for their non-service-connected disability under section 612(g).

Last in priority would be all other veterans eligible for outpatient medical services under section 612(f)(1). Even here, the Committee bill establishes priorities among categories of non-service-connected veterans. Under section 104(a)(5) of the Committee bill, veterans seeking outpatient treatment in preparation for hospitalization under section 612(f)(1)(A), or to complete treatment after hospital care has been rendered under section 612(f)(1)(B), receive priority over veterans seeking treatment to "obviate the need for hospital admission" under section 612(f)(1)(A), since bill provides that the latter category of veterans would receive care only "to the extent that facilities are available" once all other eligible veterans have been served.

The Committee recognizes that in certain instances application of these statutory priorities may raise practical and equitable problems. The Committee stresses, therefore, that under no circumstances should these priorities be interpreted to bar emergency treatment for the medical emergencies of non-service-connected veterans who do not fall within the four delineated priority categories. The Committee bill is explicit on this point: The statutory priorities do not apply "in the case of medical emergencies which pose a serious threat to life or health." (Section 104(a)(9).) Nevertheless, the Committee recognizes that difficult cases will inevitably arise under any such standard, especially in such a complex and sensitive area.

In resolving such cases, the Committee expects the following general principles to be applied. First, the purpose of establishing priorities is to ensure that care is provided first to those who, as a matter of national policy, have a primary claim to attention, and this purpose would clearly be defeated if exceptions to the priority scheme were made routinely or as a matter of course. Second, the ultimate determination of eligibility for immediate care should be made by the physicians who examine the veteran, and should be based on their sound medical judgment as to whether the denial of immediate care would pose a serious threat to the veteran's life or health. Third, it is not the intent of the Committee bill to remove the eligibility for outpatient care of veterans seeking outpatient services for non-service-connected conditions, but merely to bring about a more efficient and effective method of scheduling the time at which such services will be furnished to them.

In order to assist the Committee and the Congress in reviewing the effectiveness of these new priorities, the Chief Medical Director should establish permit appropriate monitoring and evaluation of the implementation of the new statutory priorities.

It is the Committee's intention that the institution of a priority system will encourage the development of positive steps to reduce overcrowding and shorten waiting times in VA health care facilities. Chief among these steps is the effective implementation of an efficient centralized scheduling system and the assignment, to the maximum extent possible, of clinic appointments to all veterans (service-connected as well as non-service-connected) who need outpatient treatment. (Such a scheduling system is part of the new VA policies in

Interim Issue 10-76-21, *supra*.) Combined with centralized scheduling should be an effective effort to inform and educate veterans on the need to schedule appointments and to restrict visits to the outpatient area of the facility (except in emergency cases) to those situations when an appointment has been made in advance.

The Committee wishes to express its concern over one additional problem with respect to the statutory priorities. Under the proposed statutory scheme, five categories of veterans would receive priority for outpatient medical services. One of these categories involves veterans who are receiving increased pension or compensation as the result of a catastrophically disabling injury and who are seeking treatment for disabilities not adjudged to be service-connected. (Veterans with readjustment problems diagnosed under new section 612A of title 38 are certainly experiencing service-connected difficulties although perhaps not strictly "disabilities" as that term is defined in title 38.) Some have suggested that priority treatment be extended to other categories of non-service-connected veterans. Except as described more fully below, the Committee does not agree for the following reasons. First, as indicated above, the establishment of a priority system does not itself cut back any veteran's eligibility for outpatient care. No veteran who is otherwise entitled to medical services on an outpatient basis would be refused those services on the basis of the statutory priorities. For bona fide medical emergencies, immediate care would still be available, and for the treatment of all other disabilities care authorized to be provided would be provided pursuant to an appointment schedule or similar priority-assigning mechanism. Second, the purpose of a priority system would be defeated if too many categories of veterans were entitled to priority care.

The Committee believes that one exception to the above discussion should be made to take into account the special needs of lower-income veterans with catastrophic disabilities who, because of incomes which exceed the maximum income limitation, are not eligible for pension or aid and attendance under section 612(g). These non-service-connected veterans have modest incomes averaging less than \$7,000 a year—enough to disqualify them from receiving pension and aid and attendance as described in section 612(g) (and thereby from receiving priority attention for outpatient services under the Committee bill), but obviously generally far less than they need to cope with the high costs of treatment for catastrophic injury. The Committee therefore intends that these veterans should be accorded priority for outpatient care over all other eligible non-service-connected veterans who are not included in the statutory priority scheme.

Expanding Automatic Outpatient Care Eligibility for Service-Connected Veterans

Closely related to the provisions in the Committee bill establishing priorities for outpatient care is a provision (contained in section 104 (a) (7) of the bill) to extend the eligibility for total VA outpatient care for any disability to veterans with disabilities rated at 50 percent or more—as of June 30, 1976, approximately 488,000 veterans. Under current law, in section 612(f) (2) of title 38, only veterans rated at 80 percent or more—175,248 as of July 1, 1976—are eligible for this full range of outpatient services.

This proposed expansion of section 612(f)(2) to approximately 300,000 very seriously service-connected disabled veterans is really part and parcel of the new statutory priority hierarchy, since the greater number of veterans with serious service-connected disabilities who will be made eligible for total outpatient services because of this amendment will necessarily expand the number of service-connected veterans who will receive priority treatment over non-service-connected veterans.

Refocusing Fee-Basis Outpatient Care

Just as significant as the rapid growth in outpatient staff visits during the past decade is the exceptional growth and size of the fee-basis program. Neither the statute nor VA regulations distinguish very carefully between fee-basis outpatient care eligibility for service-connected and for non-service-connected veterans. As competition continues to increase for relatively limited resources in the VA system, it is imperative that such distinctions be drawn. The Committee bill provides a first step in that direction.

Under current law, section 601(4) of title 38 defines the term "Veterans' Administration facilities". Section 302(b)(2) and (3) of the Committee bill amends clause (4) to make clear that the VA may contract for fee-basis service only when VA or other Federal hospitals or clinics "are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the particular type of care or services required". The effect of this new language is to limit the authorization of fee-basis service—for service-connected or non-service-connected disabilities—to those situations when regular VA hospitals and clinics (or other Federal facilities) are genuinely unable to provide the needed services themselves.

In addition to this general limitation on fee-basis service, the Committee bill, by section 104(a)(4), applies to the provision of fee-basis services to veterans for the treatment of non-service-connected disabilities a specific limitation—"within the limits of Veterans' Administration facilities". This phrase as to fee care for service-connected disabilities now appears in section 612(a). The addition of this phrase to 612(f) overrides a strained VA interpretation as to its present authority to authorize fee care for non-service-connected disabilities. (The term "Veterans' Administration facility" is specifically defined in present section 601(4) to include fee care only for service-connected disabilities. Since this term (which provides an authorization as well as a limitation) does not presently appear in section 612(f), which provides for outpatient treatment for veterans with non-service-connected disabilities, the VA has, in anomalous fashion, interpreted this absence to mean that fee-basis treatment is authorized under all circumstances for non-service-connected disabilities.) Apparently recognizing the extent to which this statutory construction, although perhaps literally correct, strains common sense and could not have been intended by Congress, the VA has not broadly utilized such interpretation to provide contract care to non-service-connected veterans.

Thus, section 302(b)(2) of the Committee bill amends the definition of "Veterans' Administration facility" so as to limit fee-basis or contract care to seven specific categories of veterans, as follows:

1. Veterans requiring inpatient or outpatient treatment for a service-connected disability;

2. Those requiring inpatient or outpatient treatment for a disability which led to discharge from the Armed Forces;

3. Those requiring outpatient care who have service-connected disabilities rated at 50 percent or more, under section 612(f)(2) (as amended by section 104(a)(7) of the Committee bill);

4. Those requiring post-hospital outpatient care for disabilities—whether or not service-connected—under section 612(f)(1)(B) (for up to 12 months after hospitalization, except that such 12-month period may be extended to the extent necessary to treat the particular condition being treated and if other Federal reimbursement is not reasonably available to defray substantially the cost of such services);

5. Those requiring hospitalization for treatment of a disability for which the VA is not capable of caring within the resources available in its own health care facilities;

6. Women, veterans; and

7. Veterans residing in Alaska, Hawaii, or an American territory or possession.

In no circumstances, other than these seven specific ones, would fee-basis outpatient or hospital care generally be authorized. A patient seeking outpatient care for a non-service-connected disability, for example, would not be eligible for care on a fee-basis if care were needed solely to obviate the need for hospital admission, or to prepare the veteran for hospitalization.

Beneficiary Travel

Under current law (section 111 of title 38) a VA beneficiary may pay his or her own expenses of travel by personally owned conveyance and be reimbursed on a mileage basis—under present VA regulations at 8 cents per mile. Although this reimbursement rate is considerably below the 11 to 16 cents per mile paid to Federal employees who use their own vehicles in situations deemed to be “advantageous to the Government”, the total cost of this VA beneficiary travel reimbursement in fiscal year 1975 still amounted to \$44 million, and the cost was budgeted at \$50 million in fiscal year 1976.

Concerned by the rapid increase in the cost of the beneficiary travel reimbursement program and by a decision by the Office of Management and Budget—reflected in the VA’s fiscal year 1977 budget request for medical care, holding beneficiary travel reimbursement expenditures to \$50 millions—that further cost increases would have to be absorbed within the VA’s medical program budget, several hospitals in the VA system, over the last year instituted a new reimbursement policy, under which all veterans would receive reimbursement only for the cost of public transportation to and from the VA facility.

Neither the statutory reimbursement policy contained in section 111, nor that administrative policy (of providing, in certain areas, bus-fare reimbursement only) makes any distinction between veterans seeking care for service-connected and those for non-service-connected disabilities.

Section 101 of the Committee bill proposes a new statutory policy to make that distinction very clearly. On July 26, after this bill had been ordered reported, DM&S implemented a new policy substantially

in line with the new policy and procedure established in the Committee bill. (That document is set forth in the Appendices to this report.) It is thus widely understood that beneficiary travel reimbursement costs must be brought under control, especially since continued growth would likely be at the expense of more vital aspects of the VA's medical care program.

Under section 101 of the Committee bill, veterans being treated for non-service-connected conditions would be entitled to reimbursement (even at the reduced public transportation rates specified in the bill) only if they were determined to be unable to defray the expenses of travel out of personal funds. The determination of inability to pay would be made annually, and would be based on an annual declaration and certification of such inability.

Unlike the oath of inability to defray the expenses of necessary hospital care, which, under section 622 of title 38, is by law conclusively presumed to be sufficient evidence of inability to pay, the declaration and certification procedure, established by the Committee bill as to beneficiary travel, would permit the VA to investigate the financial circumstances of veteran-applicants, and would subject veterans who make untruthful statements concerning their finances to criminal sanctions (under 18 U.S.C. 1001). (Veterans applying for beneficiary travel reimbursement should thus be advised orally and in writing of the consequences of any knowingly false statements.)

A veteran being treated for a service-connected disability or for a non-service-connected disability if otherwise rated as 50-percent-or-more-service-connected disabled, or being examined in connection with a disability compensation claim would retain automatic eligibility for beneficiary travel reimbursement.

Moreover, under the bill, veterans eligible for travel reimbursement would be paid only for the cost of commuting to VA facilities by public transportation (unless public transportation costs exceed the costs of travel by privately owned vehicle, in which case veterans would be reimbursed for the latter costs). Thus, if a veteran travelled by car, he or she would still be entitled to the public-transportation-cost reimbursement. Exception to the public-transportation-cost reimbursement rule would be made in only two circumstances: If public transportation were not reasonably accessible, or if travel by public transportation would be medically inadvisable. In such cases, reimbursement for the full cost of travel by privately owned vehicle would be authorized.

It is believed that this revised policy and procedure will yield a savings of at least \$10.18 million in fiscal year 1977.

Home Health Services Home Modifications

Under section 601(6) of title 38, as amended in 1973 by Public Law 93-82, veterans are eligible for "such home health services as the Administrator determines to be necessary or appropriate for the effective and economical treatment of a veteran." Under the home health services program, the VA is presently authorized to make necessary improvements to the home of a hospitalized veteran, in order to permit that veteran to leave the hospital and to receive treatment at home. Examples of home improvements are the construction of temporary ramps to permit access to the house by wheelchair, electrical adjustments to permit the operation of dialysis equip-

ment, and the installation of air-conditioning equipment or winterizing insulation.

No distinction is now made in law between the kinds of home health services available to a veteran being treated for a service-connected disability and those services available to a non-service-connected veteran. An additional problem has arisen because of the restrictive definition of "home health services" which the VA, in a series of recent General Counsel Opinions, has adopted. The VA has held that it has no authority to expend medical care funds to make permanent improvements to the realty or structural alterations in the home of a veteran, and has therefore refused to pay for two of the most commonly-needed home improvements—widening bathroom doors to permit the entry of a wheelchair, and constructing driveways, paths, and ramps to facilitate wheelchair access from automobile to home and from room to room within a home—even though some of these improvements would cost far less than many other "services" (such as drilling a well for a kidney dialysis patient) provided as home health care, often for non-service-connected disabilities. The result of this kind of distinction can be that veterans with minimal financial resources—particularly those confined to wheelchairs as the result of paralyzing spinal cord injuries—remain in VA hospital beds, at considerable expense to the Federal Government and despite the well-established social and psychological imperative to discharge such patients from in-hospital status before their dependence on hospital routine interferes with their therapeutic and rehabilitative progress.

The Committee bill is designed to improve the home health services program in two ways. First, it would distinguish for the first time between services available to service-connected and non-service-connected veterans. For certain veterans suffering from a non-service-connected condition, the VA would be authorized (under section 104(a)(8) of the Committee bill) to furnish home health services necessary or appropriate for the effective and economical treatment of the condition, but only to the extent that any improvements or structural alterations made to the veteran's realty or home are "of a minor nature" and only when necessary to assure the continuation of treatment or to provide access to the home or to lavatory facilities. Only certain veterans would be eligible for home health services for non-service-connected disabilities, as part of the outpatient "medical services" to be furnished under section 612(f) of title 38. Under the definition, as revised by the bill, of "medical services" in section 601 of title 38, only those veterans in need of post-hospital care or with service-connected disabilities rated at 50 percent or more would be eligible for home health services for the treatment of a non-service-connected disability—and then only for home improvements "of a minor nature". The original Congressional intent was to include within home health care eligibility only those non-service-connected veterans who had been hospitalized, and (although the Committee is not aware that the VA has applied the present home health authority to extend to pre-hospital and obviate-hospitalization outpatient care) the Committee bill thus provides that limitation expressly.

By improvements or alterations of a "minor nature", the Committee means those costing \$500 or less in the case of any one veteran, and the Committee intends that this limit be strictly applied. For covered

improvements costing more than \$500, the veteran would pay the remaining cost from other sources.

For veterans receiving treatment for a service-connected disability, however, the Committee bill proposes that a broader range of home health services be available. Under section 104(a) (1) of the Committee bill, home health services would be authorized for the treatment of service-connected disabilities when "necessary or appropriate for the effective and economical treatment of such disability". As in the case of a non-service-connected veteran, covered home improvements and alterations would be those necessary to assure the continuation of treatment or access to home or lavatory facilities, but home improvements would not have to be of a "minor nature". Instead, the Committee bill limits the cost of such improvements or alterations for the treatment of a service-connected disability to the cost of the average period of hospitalization in VA hospitals, as determined annually by the Administrator. In fiscal year 1976, the average hospital stay was 26 days, and the average cost per day was \$87.86. The cost of the average period of hospitalization, therefore, was approximately \$2,284 in that year. In the future, the average length of stay will probably continue to decline and the average cost per patient day to increase; the cost of the average period of hospitalization will probably remain in the vicinity of \$2,500 to \$3,000. This figure—as determined precisely by the Administrator on an annual basis—would be the maximum which the VA could spend on improvements or alterations for treatment of a service-connected condition of any particular veteran; as in the case of a non-service-connected veteran, the veteran could pay any amount over the maximum figure from other sources.

The second improvement over existing law made by the Committee bill is the clarification in the kinds of projects which the VA would be authorized to support under the home health service program. The artificial distinction of whether the alteration is a permanent improvement to the leasehold would no longer be in any way appropriate. Instead, the bill specifically authorizes improvements and alterations to provide access to the home or to essential lavatory and sanitary facilities, such as wheelchair ramps, improved paths and driveways, and construction to widen bathroom doors and install grip bars or other functional features therein.

The average costs of basic home health items exemplifying those allowable under the Committee bill are shown in table 4.

TABLE 4.—*Estimated average costs for selected home health service items*

Item:	Total cost (includes installation and labor)
Air-conditioner, window model.....	\$350.
Central air-conditioning system.....	\$1,600 to \$5,000.
Widening doorway.....	\$150 to \$300.
Lavatory grab-bars.....	\$400 to \$700.
Drilling and installation of a well.....	\$7.50 per vertical foot.
Wheelchair ramp.....	\$5.00 per square foot.
Electro-lift for staircase.....	\$1,000 to \$2,500

Source: Figures supplied by the Department of Medicine and Surgery.

Outpatient Family Counseling

Physicians, particularly psychiatrists, in the VA health care system have repeatedly stressed that the effective treatment of a veteran is

often not possible unless family members are also available for treatment and counseling. Total care of a physically or emotionally disabled veteran may require that members of the veteran's family be fully oriented on the philosophy, goals, and achievements of the veteran's treatment or rehabilitation program. This is particularly important to the treatment of veterans suffering from alcohol- or drug-related conditions.

Necessary involvement of family members is presently authorized under section 601(5) of title 38, but (due to an oversight in Public Law 93-82), only when the veteran is receiving hospital care. For veterans receiving medical services on an outpatient basis, there is no statutory authority for such mental health services or counseling for family members. As a result, it is frequently difficult to provide effective treatment and rehabilitation—especially mental health care—for a veteran being treated on an outpatient basis.

In correcting this situation, the Committee has been very much aware of the VA's financial, personnel, and physical resources, and the Committee bill thus places a limit on the services which can be provided to family members incident to outpatient services provided to veterans, by distinguishing between services provided in connection with treatment of service-connected and non-service-connected disabilities in order to ensure that scarce funds are expended first for the care of the service-connected.

Section 102(2) of the Committee bill would amend section 601(6) of title 38—the definition of “medical services” for which veterans are eligible on an outpatient basis under section 612 of title 38—to authorize a range of family services when essential to the effective treatment and rehabilitation of the veteran. (The VA's existing authority to provide such services to the family members of inpatient veterans would continue unaffected; the reference to family mental health services now contained in section 601(6) would not be affected by the clarifying amendments made in section 102(1) of the Committee bill.) The nature of the services available under the Committee bill to family members of veterans treated on an outpatient basis, however, would in several respects be significantly different from the services available to inpatient family members.

First, the family members of a veteran treated for physical conditions (in other words, medical or dental conditions other than mental health conditions) would be entitled to such consultation, professional counseling, and training as may be essential to the effective treatment of the veteran. Such services would be available to the family members of non-service-connected as well as service-connected veterans.

Second, the family members of a veteran receiving treatment for a service-connected mental health condition would be entitled to mental health services (including psychiatric consultations and other outpatient professional services) in addition to the consultation, counseling, and training described above. The same would be true for family members of a veteran receiving followup mental health services for a readjustment problem after initial readjustment professional counseling under the new section 612A added to title 38 by section 105 of the Committee bill.

Third, the family members of a veteran suffering from a non-service-connected mental health condition would have limited eligibility

for the same range of outpatient mental health services, but only (1) in the discretion of the Administrator, (2) if the veteran is receiving outpatient mental health care to complete treatment incident to care formerly received as an inpatient, and (3) if family services were commenced prior to the veteran's discharge as an inpatient.

NEW HEALTH CARE PROGRAMS

Introduction

After the period of unprecedented growth and expansion for the Department of Medicine and Surgery over the past 7 years, consolidation of the budgetary and other gains must proceed along two lines.

First, steps must be taken to ensure that existing resources are expended in the first instance for the benefit of those with a primary claim to attention—veterans with service-connected disabilities. This is the first principal purpose of the Committee bill, as described in detail above.

Second, new medical programs must be designed to promote long-term cost savings through timely identification of disease symptoms and medical intervention in the early stages of disease. The Committee bill contains authority for three such new programs, each designed to identify and treat veterans with service-connected disabilities, or conditions which for many veterans began during service and for which early detection and treatment may forestall the onset of chronic illness.

Preventive Health Care Program

One of the major new departures in VA health care proposed in the Committee bill is contained in section 110 of the reported bill. The new subchapter which would be added to chapter 17 by that section would expand the scope of health care offered by the Veterans' Administration to certain veterans to include preventive health care services. These services would be available, as feasible and appropriate, for all veterans suffering from a service-connected disability rated at 50 percent or more, and to any veteran in connection with treatment for a service-connected disability (that is, as part of a hospitalization or outpatient visit for that purpose). It is estimated that approximately 488,000 veterans have service-connected disabilities rated at 50 percent or more and that 2.2 million have some service-connected disability.

Currently, health care in the Veterans' Administration is generally defined by statutory language as services to treat an already existing disease or disability (except for a specific program for sickle cell screening and counseling in subchapter VI of chapter 17). This definition follows the traditional practice in the medical community of treating identified disease and alleviating existing pain. However, within the past decade or so, more and more thought has been given to shifting the emphasis in medical care toward the prevention of illness or disease. Many public health experts believe that such an emphasis would significantly improve health in the long run, and might also result in significant long-term cost savings for individual patients and for the Nation as a whole.

The Committee bill, by authorizing the VA to provide only such preventive health care services as "are feasible and appropriate" and "necessary for providing effective and economical preventive health care" on a national or geographic basis, vests discretion in the Chief Medical Director in establishing the nature and mix of services to be furnished in the program, the schedule for phasing in various services, and the identification of those facilities best equipped to provide them. Under the new subchapter at least one preventive health care service would be required to be offered to each veteran made eligible for such services.

The reported bill authorizes the VA to institute appropriate controls and carry out followup studies, which may include research, to demonstrate the medical advantages and cost-effectiveness of furnishing such preventive health care services. Research would seem to be a particularly important aspect of this new program since the VA is in an almost ideal situation to make a major contribution to knowledge in this field.

Among those preventive health services which the legislation suggests may be included are:

First: Periodic medical and dental examinations.—This does not mean an annual physical—a costly procedure which experience has shown does not ensure freedom from serious illness. Rather, the Committee envisions, as one type of program at selected locations, preventive services packages geared to age groups as suggested in a report to the National Conference on Preventive Medicine by a prestigious task force, headed by Dr. Lester Breslow, Dean of the School of Public Health at the University of California at Los Angeles, who presented impressive testimony on the value of a preventive health program to eligible veterans. This task force recommended a pattern of routine physicals for individuals during the following life periods: Two from ages 18 through 20, three from ages 31 through 40; four in the next decade; and five between ages 51 and 60. Annual physicals are recommended for those over age 60, with the nature of the tests included changing at specific ages. The task force also noted that above the age of 35, additional screening measures should be performed, such as screening for hypertension, cholesterol level, cancer, glaucoma, kidney disease, emphysema, and cardiac problems among others. The Committee believes that the VA is in an excellent position to implement this kind of program at selected hospitals and that this can be integrated at reasonable cost, with other health care visits made by disabled veterans.

Second: Patient education.—As medical science has conquered some of the serious and widespread diseases of previous generations, such as diphtheria, typhoid, and tuberculosis, today's citizen is more susceptible to other major diseases, such as cancer and heart disease, as well as chronic diseases which are aggravated either by personal habits such as smoking, overeating, lack of exercise, alcohol abuse and drug abuse, or by environmental hazards, such as noise or pollutants. With a modest investment in health education programs, many experts believe substantial progress can be made toward the control of these diseases. In addition, counseling as to diet and personal health habits should be an integral part of every patient contact with a health specialist. Patient education (including nutrition education) programs

should be an integral part of a preventive health program and can achieve health benefits at a minimal cost.

Third: Maintenance of drug use profiles, patient drug monitoring, and drug utilization education.—Where clinical pharmacy services of this scope have been utilized, studies indicate that medication error rates have decreased substantially, that inappropriate drug utilization has been reduced, that adverse drug reactions have been averted, and that substantial dollar savings have been realized. Including these clinical pharmacy services in a preventive health program is important if the program is to deal with the high incidence of adverse drug reactions and interactions.

Drugs are responsible for approximately 10 percent of total health care expenditures in the United States. In fiscal year 1976, the VA spent approximately \$160 million on drugs and medicines. The effect of adverse drug reactions on the recovery of the veteran patient, as well as the possibility of long-term injury or disability resulting from improper prescription or utilization of drugs, requires greater focus in the provision of VA health care services. Recent surveys of community hospitals have indicated that the incidence of adverse drug reactions is substantial. It is estimated by initial studies that from 3 to 6 percent of all admissions to tertiary-care hospitals are due to adverse drug reactions, and that a minimum of 15 to 18 percent of patients at those hospitals suffer an adverse reaction subsequent to their admission. Since these adverse reactions may well on the average double the patient's hospital stay, the unnecessary costs involved are overwhelming.

As the number and complexity of available prescription and non-prescription drug products increases, and the use, abuse, misuse, and overuse of drugs continues to rise, the need for improved pharmacy services becomes more urgent.

In recognition of the complexity of prescription drug management, the health community has developed a relatively new professional—the clinical pharmacist. Clinical pharmacy training prepares the pharmacist for greater responsibility in direct relationships with the patient in drug abuse, toxicity, and nonprescription drug advice as well as in closer working relationships with physicians, dentists, and other health professionals. The specialized training of the clinical pharmacist is designed to enable that professional to relieve a great many of the demands made upon physicians, freeing the physician for duties most appropriately performed by such a highly trained professional.

A study, carried out in 1972, entitled "An Application of Clinical Pharmacy Services in Extended Care Facilities," evaluated the impact of clinical pharmacy services on the apparent quality of patient care and cost-effectiveness of drug therapy in skilled nursing facilities. Three 91- to 99-bed facilities in Los Angeles County, which met a set of predefined criteria, were randomly selected for the study. A pharmacist with clinical training and experience was appointed to provide optimal pharmaceutical services and care in order to bring about more safe and rational use of drugs in these facilities. Pre-study and post-study evaluations were conducted and data were analyzed by expert consultants. The results of the study were as follows:

1. The medication error rate was reduced by 50 percent.

2. Drug utilization was reduced by 20 percent through discontinuation of unnecessary and inappropriate drugs.

3. Sixty or more clinically significant adverse drug reactions were detected and/or prevented.

4. A cost-saving of \$80,000 a year was projected in the three facilities studied.

5. The pharmacist functioning in this capacity was well received by the patients, physicians, administrators, and especially by the nurses.

A similar study is proposed for the VA outpatient clinic in Los Angeles. The objective is to evaluate the quality of patient care and cost effectiveness of drug therapy through monitoring and evaluating drug therapy of ambulatory care patients by clinically-trained pharmacists.

Preliminary data for that walk-in clinic indicated that 30 to 40 percent of VA patients who visited there were considered to be prescription drug-related. The main reasons for visits to the clinic by this group of patients were:

1. Refill or renewal of prescriptions.

2. Request for drug information or counseling because the patients were confused in taking their prescribed medications or complained of some undesirable responses.

3. Seeking new treatment or new medications.

A clinically trained pharmacist was appointed to counsel this group of patients and to review their drug utilization from October 1, 1974, to December 31, 1974. This study concluded that 27 percent of patients complied with the prescribed medication directions; 39 percent overutilized medications; 31 percent underutilized medications; 7 percent had excessive prescribed dosages; 2 percent had inadequate prescribed dosages; 2 percent had inappropriate prescribed dosing intervals; 7 percent had possible or probable prescribed drug interactions; 17 percent had possible or probable adverse drug reactions; and 23 percent had inappropriate combinations of drugs or duplications.

These findings indicate the dimensions of the demand that can be made upon one VA facility by veterans with drug-related problems. In the Committee's view, this problem can be substantially corrected by greater emphasis on comprehensive clinical pharmacy services within a preventive health program, and such services should be implemented at a number of facilities on a pilot basis to test their cost-effectiveness and total health care impact.

Fourth: Routine vision testing and eye care services.—These services are important not only for early detection of eye disease, but also for detecting other illnesses, such as diabetes or cholesterol imbalance. Furthermore, since the average veteran is now an older veteran—14 million are World War II veterans with a median age of 55, and 1 million are World War I veterans of at least 75 years of age—preventive vision services could improve daily living for many veterans. These services can be provided very effectively by an optometrist—a professional much underutilized by the VA. The Committee does not envision the provision of eye glasses or contact lenses as part of this service.

Other Preventive Health Care Services

Of course, a total preventive health care program should also include immunizations, prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature, genetic counseling, and early intervention in mental illness, including family counseling.

Use of Paraprofessional Personnel

The Committee bill directs that interdisciplinary health care teams be utilized, to the maximum extent feasible, in carrying out preventive health care programs. In a system as large as the VA, which is generally not bound by the restrictions of State licensing laws, an opportunity exists to implement a major program of this nature, utilizing paraprofessionals in new roles and in ways which can reduce the demands made upon the more highly trained professional. Legislation recently enacted as Public Law 94-123, the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975, enables the VA to hire physician assistants and expanded-function dental auxiliaries on a competitive basis with the community. The Committee expects such personnel to play a substantial role in the new preventive health care programs.

Cost

The Congressional Budget Office estimates the costs of the preventive health care program for service-connected veterans at \$3.01 million during fiscal year 1977 (beginning on January 1, 1977), based on the provision of three selected preventive services to each eligible, participating veteran plus hospitalization costs based on a rate of 1 percent detection of morbidity based on the three screening tests. The three services envisioned would be electrocardiograms and hypertension screening for the detection and early diagnosis of heart disease and other cardiac conditions, tonometry for glaucoma detection, and a proctoscopic examination for detection and early treatment of rectal cancer and other colonic disorders. The cost of providing these three simple services would be \$8.25 per veteran. The projected first year cost of \$3.01 million would be made up of \$1.36 million for the preventive health services, and \$1.65 million for the induced hospitalization.

Comprehensive Health Maintenance Pilot Program

In addition to authorizing a preventive health care program for the approximately 500,000 veterans with a service-connected disability rated at 50 percent or more and for veterans being treated for service-connected disabilities, the Committee bill would mandate the VA to carry out an experimental health maintenance pilot program in comprehensive health care services, including a research component. Such services would be furnished to service-connected veterans in accordance with the priorities for outpatient services specified in the proposed section 612(i) in a VA hospital on an inpatient or outpatient basis.

The reported bill directs that the pilot program be undertaken as a controlled, scientifically valid study of the provision of such HMO-type service to no more than 10,000 veterans (including control groups), and limits the pilot program to a 10-year period.

The Congressional Budget Office estimates that the cost of providing health care under an HMO-type configuration would be \$600 per year per individual. With 5,000 individuals in the control group and 5,000 in the HMO, the costs are estimated at \$3.5 million the first year, increasing to \$4.29 million the fifth year, when inflation is taken into account. This estimate includes \$500,000 a year to cover the costs of generating, maintaining and analyzing the data developed in the pilot program.

The reported bill requires the VA, in carrying out the preventive health care program as well as the comprehensive health care pilot program, to emphasize the utilization of interdisciplinary health care teams composed, to the maximum extent feasible, of various professional and paraprofessional personnel.

The findings from such a program should have broad application to health care programs not only in the Veterans' Administration, but also in the medical community at large. In view of the inevitability of some form of national health insurance program in the next few years, the experience gained from a preventive health program operating on a scale of sufficient size, as is possible in the Veterans' Administration, should provide a good estimate of the achievable benefits of many preventive health measures.

Lead Time for Planning

To provide the necessary lead time for planning the basic preventive health care program and designing the pilot program, the Committee bill postpones the effective date of the preventive health care service program until January 1, 1977, and the implementation date of the pilot program until October 1, 1977.

READJUSTMENT PROFESSIONAL COUNSELING

Section 105 of the Committee bill would establish a new program to provide initial readjustment professional counseling for veterans discharged since the beginning of the Vietnam era (August 5, 1964) to assist with psychological readjustment problems, generally those arising within 4 years of discharge from active military duty.

Initial Counseling

Under section 105 of the Committee bill, the Administrator is to provide an in-house program of initial professional counseling for any eligible veteran who served in the Armed Forces after the beginning of the Vietnam era, who generally meets the eligibility requirements of chapter 17, and who requests assistance with readjustment problems within 4 years from the date of his or her discharge or release from active duty. In connection with this counseling, the VA would also make a general mental and psychological assessment of the veteran. Veterans discharged 2 or more years prior to the enactment date of the reported bill would have 2 years from that enactment date within which to apply for counseling under this section.

In providing counseling services under this section, the Chief Medical Director would be required to make maximum use of paraprofessional and voluntary workers, as well as veteran GI bill students under the veteran-student services work-study program, to assist in initial intake and screening. The Committee believes that much of the initial

intake and screening can be effectively provided by trained paraprofessional personnel and volunteer workers who become especially sensitive to the readjustment needs and problems of returning and returned veterans. Use of highly trained psychiatric personnel should be limited to those cases identified by the screening process as needing such highly professional services.

Followup Mental Health and Other Services

If the initial counseling indicates that followup mental health services are necessary to facilitate the successful readjustment of the veteran, the Committee bill provides for such services to be furnished on an outpatient basis as a part of medical services provided under the conditions specified in section 612(f)(1)(B) of title 38—post hospitalization. No financial need would need to be shown for the initial counseling, but the regular eligibility criteria under section 612(f)(1)(B)—including inability to defray expenses—would apply in the case of needed readjustment mental health services, except that the provision of the initial counseling period would be deemed by law to satisfy the requirement for a prior period of hospitalization under that statutory provision.

Veterans who, on the basis of the initial counseling, are determined to be in need of hospital care or medical services other than mental health services for a readjustment problem, would be eligible to receive the needed care in VA facilities only if otherwise meeting chapter 17 eligibility requirements; if not, they would be referred to non-VA facilities.

Readjustment Problems

The purpose of this readjustment counseling provision is to make fully available—and to encourage and facilitate the use of—the resources of the VA's health care system to those returning veterans who feel the need for professional counseling to help them in their readjustment to civilian life. According to testimony from a panel of psychologists and veterans' counselors at the February hearings, veterans of the Vietnam era have suffered significantly as the result of society's indifference and, in some cases, overt hostility to the sacrifices they made during their periods of military service. Large numbers of returning Vietnam veterans have experienced guilt, bewilderment, alienation, pessimism, tension, restlessness, and other symptoms of low-grade readjustment problems. These problems frequently result in family difficulties, unemployment, alcohol or drug dependence, arrest records, and other forms of social and economic dislocation. Testimony at the hearings on the bill indicated that the readjustment problems facing returning Vietnam veterans have been particularly acute. This view had also been expressed in the Congressional testimony of distinguished psychiatrists since 1969. Their conclusions were echoed in a 1972 study on the psychosocial problems of Vietnam veterans:

The psychological and social problems of the Vietnam veteran probably exceed those of any previous conflict; yet many of the very factors which help to keep psychiatric casualties low in Vietnam ironically seem to compound the readjustment difficulties of the veteran when he returns.

The Committee construes a "readjustment problem", as that term is used in this section, to be a low-grade motivational or behavioral impairment which interferes with a veteran's normal interpersonal relations, job or educational performance, or overall ability to cope reasonably effectively with his or her daily life problems. A readjustment problem does not necessarily amount to a definable psychiatric illness or mental health problem requiring extended professional services (including psychiatric consultations) but could become one in the absence of early detection and counseling and followup care where necessary.

In the sensitive field of readjustment counseling, it is essential that services be available and accessible, on an outpatient basis, and that all unnecessary barriers to help be removed. The Committee bill is designed to achieve this result. A veteran recently discharged from active duty should know that such help is available, and that a request for readjustment counseling will be speedily honored, with a minimum of red tape, and, most importantly, without the need for prior hospitalization. Such prior hospitalization is in fact a requirement under present statutory criteria unless—as is extremely unlikely under the present law—a condition is adjudicated to be service-connected, or outpatient care is deemed necessary "to obviate the need" of hospitalization. The Committee doubts that any fair application of the "obviate" criterion would lead to its use extensively in a psychiatric context and certainly not in the context of low-grade readjustment problems which have not developed into any form of identifiable psychiatric illness. In a June 21 response to a written question submitted by the Subcommittee Chairman for the hearing record, the Chief Medical Director seemed to concede as much, by saying:

It is neither efficient nor humane to hospitalize a veteran for a psychiatric condition if it can be avoided. Mental health professionals are confronted with a professional and ethical issue since it is accepted medical practice to avoid hospitalization unless absolutely necessary because the patient cannot function and/or may be dangerous to himself or others. Treatment must either be withheld entirely or hospitalization unnecessarily provided. In our judgment, for the psychiatric patient "obviate" should mean timely therapeutic intervention that would reduce the likelihood of further deterioration of controls that, if not treated, would be likely to result in eventual though not immediate hospitalization.

The Committee believes that the last sentence of the above quotation aptly illustrates the point made above about the general inapplicability to general mental health problems of the "obviate" criterion on any fair reading of the law and legislative history.

Outreach

Under the Committee bill, the Administrator, acting in coordination with the Secretary of Defense, would also be responsible for notifying all veterans eligible for readjustment professional counseling under the new section 612A of their eligibility for such services.

Cost

Preliminary Committee estimates are that 5 percent of the more than 7 million veterans who served in the Armed Forces after August

4, 1964 (the beginning of the Vietnam era), would request readjustment counseling, as would 5 percent of those veterans discharged in subsequent years. Thus, it is expected that about 354,400 current veterans would seek this counseling (204,500 in the coming fiscal year and 131,300 in fiscal year 1978), with an additional 25,000 annually in subsequent years. The average number of visits per veteran would be between 2 and 3.

The use of paraprofessional personnel mandated by the reported bill would reduce the costs of the counseling program. In addition, the more restrictive authorization of reimbursement for beneficiary travel would apply to veterans seeking readjustment counseling and would keep travel costs to a minimum. Thus, projected annual costs for this program beyond the initial 2 years are estimated at around \$1 million for counseling and \$2 to \$3 million for followup mental health care. The cost of followup mental health services would be to provide new staff at certain sites to ensure outpatient mental health care capacity to meet the demand for services generated by the initial counseling.

The Committee notes that it may be necessary to give the VA a period of leadtime such as for the preventive health care program (January 1, 1977), before this amendment to title 38 becomes effective, in order to permit necessary planning and the training of the necessary personnel, particularly volunteer and lay personnel.

Drug and Alcohol Treatment and Rehabilitation

Neither drug addiction nor alcoholism are new problems to the Veterans' Administration. For years, the VA has treated the medical consequences of both drug abuse and alcohol abuse in its hospitals. Furthermore, the VA has long recognized alcoholism as a treatable condition. Alcoholism treatment units have been established at 73 VA medical facilities, and almost 100,000 veterans received treatment for alcoholism and alcohol-related problems in fiscal year 1976. The Department of Medicine and Surgery, according to the VA's planning document of November 14, 1974, planned to activate an additional 32 alcohol dependence treatment programs during fiscal year 1976. However, the VA has activated only two of these programs.

There are 53 VA special drug treatment units operating now, with a capacity to treat approximately 29,500 patients annually and an average per-unit funding level of \$216,000. The problem of drug abuse continues to grow. Admissions for drug dependence treatment increased 35 percent for the first 6 months of fiscal year 1976 as compared to the same period for fiscal year 1975. The VA expects to meet this increased need within existing program locations but with increased resources.

Approximately \$96 million was included in the fiscal year 1977 medical care appropriation for substance abuse treatment programs.

Despite the recent—although not sufficient—growth of the VA programs for treatment of drug and alcohol abuse, the VA is still limited in several ways from responding fully to the needs of the veteran addicted to drugs or alcohol.

Title II of the Committee bill would provide for comprehensive treatment and rehabilitation programs for veterans suffering from alcohol or drug addiction. The provisions of title II are comparable to legislation passed by the Senate during the 92d (S. 2108) and 93d

(S. 284) Congresses. The Senate was unable to reach an agreement with the House in either of those Congresses. The Committee bill reflects some changes which have been made to meet concerns expressed by the House Committee on Veterans' Affairs as well as the Veterans' Administration with regard to those bills.

The Committee bill would provide the VA with the legislative authority necessary to initiate a comprehensive program for the treatment and rehabilitation of veterans suffering from alcohol or drug dependence or physical disabilities related to the excessive use of alcohol or addictive drugs.

Defined as "Disability"

First, the Committee bill would make it clear that alcoholism and drug dependence are legal disabilities for the purposes of hospital care and medical service eligibility under title 38. This is achieved in section 202 of the Committee bill by amending the statutory definition of "disability" in section 601(1) of title 38 to refer specifically to alcoholism and drug dependence as disabilities for which treatment in VA facilities is authorized.

Drug Abuse Treatment Program Eligibility Broadened

Second, the Committee bill would broaden eligibility for drug abuse treatment and rehabilitation services to include veterans who, because of the nature of their active duty discharges, would not otherwise qualify for hospital care or medical services under title 38. Under section 101(2) of title 38, the VA does not have general authority to treat drug dependent veterans—or any veteran for that matter—with less than an honorable or general discharge. (A veteran with such a "bad" discharge can be made eligible for chapter 17 health care services if he applies for and receives an adjudication that his discharge was under "conditions other than dishonorable," but the adjudication process takes many months and seldom results in a finding favorable to the veteran.)

The result of this situation has been that many thousands of veterans who have become drug addicted while in the service, primarily in Southeast Asia, and who were given a pre-amnesty-program undesirable discharge, have been denied the treatment and rehabilitative services they need to cope with this tragic disability. Under the eligibility for the drug abuse treatment program provided for in section 204 of the Committee bill, veterans with undesirable discharges and most with bad conduct discharges would be automatically eligible for drug abuse treatment and rehabilitative services—except for a very few with bad conduct discharges given by general courts martial.

Alcoholism

In the case of alcohol treatment programs, the legislation stresses the use of recovered alcoholic counselors, halfway houses, and alternative treatment modalities, in a comprehensive program ranging from detoxification to recovery. In addition, the Administrator is authorized to provide half-way house facilities directly or by contract with other Government or approved private facilities.

In a September, 1975, report to Congress on the quality of the alcohol treatment programs provided in VA facilities, the Comptroller

General of the United States found that the serious lack of DM&S staff and funds to operate alcoholism treatment and rehabilitation programs constituted a major problem. In addition, the limitations—which the Committee bill would remove—on providing outpatient counseling to the patient's family were found to pose serious handicaps to staff in trying to rehabilitate a veteran. Other findings of the study were that some of the largest major metropolitan areas—where there are large numbers of veterans—lacked any VA alcohol treatment capacity. In addition, the study found that the availability of VA alcoholism services was not adequately publicized.

There is an extraordinary and increasing prevalence of alcohol-related admissions to the VA hospital system—officially estimated by the VA at one out of every ten admissions in fiscal year 1975, making alcoholism the most common of all listed admission diagnoses. But even more revealing are the results of a comparison between a 1970 and a 1973 census in VA health care facilities which included a special question to determine which bed-occupant patients were defined alcoholics or problem drinkers. Here are the startling results:

1. The proportion of defined alcoholics and problem drinkers increased from 1 out of every 5 patients in 1970 to 1 out of every 4 patients in 1973.

2. Almost 25 percent of Vietnam-era veterans in the 1973 patient census were diagnosed as defined alcoholics or problem drinkers, as compared to 13 percent in the 1970 census.

3. Within the 35–44 age group, 35.2 percent of all hospitalized veterans were defined alcoholics or problem drinkers in 1973, as compared to 26 percent in 1970.

To meet what DM&S has called the “rapid, constant increase in that portion of the VA hospital census which represents problem cases of drinking and alcoholism,” the VA plans to establish 46 more Alcohol-Dependence Treatment Programs “as soon as funds are available.”

In view of these data and the cruel hardship alcoholism can work on veterans and their family members, it is imperative, in the Committee's view, that VA programs be expanded to face up to the virtually epidemic proportions of alcoholism among veterans and that these programs comprehensively treat the symptoms of alcoholism and aim to rehabilitate veterans suffering from this disability.

Drug Abuse

For veterans suffering from drug-related disabilities, the Committee bill would set up special treatment and rehabilitation programs to seek out and counsel addicted veterans and provide them with help in obtaining review and correction of less than honorable discharges by the military. The scope of drug treatment and rehabilitation programs would by statute be required to include individual counseling, referral services, and crisis intervention, and the VA would be required to offer alternative modalities of treatment based upon the individual needs of the veteran.

The Committee bill would also require the VA to provide treatment and rehabilitative services for any eligible veteran who has been charged with or convicted of a criminal offense, but who is not confined and is not required to participate in the program by a court.

Also, such treatment and services are authorized in the case of a veteran who is under court jurisdiction as a result of a charge or conviction for a criminal offense and who is required to participate in a treatment program by the court, but the services may be provided only under conditions which will insure that the voluntary nature of the program with regard to other participating veterans would not be impaired.

Success in treatment and rehabilitation of an addicted veteran can be heightened if the veteran is in the work force and involved in a satisfying and fulfilling job. In order to assist recovered veteran addicts in finding productive employment, the Committee bill would direct the VA to carry out a program with other Federal agencies to promote the Federal employment of recovered drug addicts (as well as alcoholics), and to cooperate with and assist the Secretary of Labor in placing these veterans with private employers.

In addition, the Committee bill would provide procedures for the treatment of active duty service personnel suffering from drug dependence in VA health care facilities if they voluntarily, in writing, request such treatment. This transfer from the Armed Forces to a VA facility would be limited to the last 30 days of a tour of duty. The purpose of requiring a written voluntary request is to preserve the fundamental voluntary basis of VA drug treatment programs. If a headstart can be achieved on the voluntary treatment of service personnel in a VA program, that should be and would be permissible under the Committee bill.

The Committee is aware that in some cases, the problems of a veteran who suffers from alcoholism or drug addiction are aggravated by the existence of a close family member who suffers from the same addiction. In such cases, successful treatment programs can often be achieved only if treatment is provided to both the veteran and the family member in one program. Since treatment of a non-veteran family member in a VA facility raises numerous difficult questions, the Committee bill would add a new authority to title 38 providing for the VA, when essential to the successful treatment and rehabilitation of a veteran, to furnish treatment and rehabilitative services to the veteran, at VA expense (limited to reasonable costs determined by DM&S), in a community facility approved by DM&S where the veteran's family member is enrolled and where both can be treated together. In such cases, the VA would not cover any of the costs of treatment of the member of the veteran's family.

OTHER GENERAL VETERANS HEALTH CARE AND DEPARTMENT OF MEDICINE AND SURGERY AMENDMENTS

Introduction

The third principal purpose of the Committee bill is to resolve some of the longstanding legal and medical problems now confronting the Department of Medicine and Surgery. Administrative experience during the past several years has revealed the need in several contexts to modify or clarify DM&S's statutory authority under title 38 in order to ensure the more effective and efficient management of existing medical programs and health care operations. The Committee bill contains several important provisions designed to achieve this purpose.

Recruitment and Retention of Health Care Personnel

No factor bears more directly on the quality of patient care provided in VA health care facilities than the qualifications and professional skills of the health care personnel in the Department of Medicine and Surgery. Health care on such an enormous scale requires a large staff of highly trained health care professionals. The Department of Medicine and Surgery employs approximately 10,000 physicians, 1,000 dentists, 25,000 registered nurses, 32,000 licensed practical and vocational nurses and nursing aides, and more than 100,000 other health care and administrative personnel.

The Committee bill contains several provisions designed to enhance the VA's ability to recruit and retain the quantity and quality of health care personnel necessary to the effective maintenance of the DM&S health care system.

Special Pay Program Extended

Section 122(a) of the Committee bill would extend for an additional 11½ months the VA's authority under Public Law 94-123, the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975, to make payments of up to \$13,500 annually in special pay to eligible physicians and dentists in the Department of Medicine and Surgery.

The most acute recruitment and retention problem faced by DM&S involves the physicians and dentists who work in VA health care facilities. The greatest single barrier to successful recruitment and retention is the inadequacy of statutory rates of basic pay for these professionals in light of the ceiling imposed by statute on all Federal Executive Schedule V employees and the resulting disparity between earnings in the VA and potential earnings in other public-sector or private practices. The result has been an exodus of experienced physicians from the VA system—an exodus which reached crisis proportions in 1975 when 300 full-time physicians resigned because they considered their salaries inadequate.

To provide temporary relief from this recruitment and retention emergency, Congress enacted last year's pay comparability law authorizing the VA to enter into agreements with physicians and dentists under which physicians and dentists receive annual special pay in return for completion of 1 to 4 years of service in DM&S. The law, enacted on October 22, 1975, and effective as of October 12, 1975, is due to expire on October 11, 1976.

To date, more than 10 months after enactment, the law has proven highly successful in halting the drain of qualified physicians and dentists from DM&S. According to the Department's report of April 30, 1976, required by the new law, on the implementation of the special pay program, 97.1 percent of all full-time physicians and 97.9 percent of all full-time dentists have signed special pay agreements for the maximum of 4 years of service, promising a major degree of retention stability for the near future. (The report is printed as Committee Print No. 36 of May 6, 1976.) The report concluded:

. . . [E]xperience [with the special pay program] so far has been good. The first quarter of FY 1976 was a very favorable recruiting period, probably related to the imminence of the pay bill. Further, full time staff was added thereafter and by March 31, 1976, the number of [full-time] physicians

on duty, 5,815, was a new high. Loss rates during the six months following the enactment of the pay bill were less than during a comparable period one year earlier. The rate for the period January through March alone was the lowest for any equivalent quarter during the year since 1968.

The Committee has also solicited and received reports from various VA hospitals which are similarly encouraging.

Because of the proven usefulness of the special pay program in attracting and retaining well-qualified physicians and dentists, the Committee believes that the VA's authority to enter into special pay agreements (for up to 4 years of service per agreement) with DM&S doctors should be extended beyond the October 11 expiration date. Section 122(a) would extend this authority for an additional 11½ months, to September 30, 1977, the date to which the authority has been extended for the special pay program for military physicians under section 313 of title 37, United States Code. That authority, which was at one point due to expire on September 30, 1976, was extended for an additional year by section 305 of Public Law 94-361 (July 14, 1976).

Special Pay for Clinical Researchers

The Department of Medicine and Surgery employs approximately 150 full-time physicians and dentists as clinical researchers in the Research and Education Career Development Program. In addition to performing their medical research responsibilities, these physicians and dentists hold staff positions at VA hospitals and devote at least one-quarter and frequently one-half of their time to direct patient care.

Under section 4118(a)(3) of title 38, as added by Public Law 94-123, last year's physician and dentist pay comparability law, the Chief Medical Director may deem categories of physicians and dentists ineligible for special pay when he makes a finding that there is "no significant recruitment and retention problem" with respect to such categories. In October, 1975, the Chief Medical Director, consistent with his prior public statements as to his intentions if a special pay law were enacted, exercised this statutory authority to exclude 248 physicians and dentists from eligibility for special pay. This amounted to approximately 4 percent of DM&S's 6,200 full-time physicians and dentists. Included were all 150 clinical researchers—the largest single group excluded administratively from special pay.

In the 10 months since the Chief Medical Director's decision to exclude clinical researchers, about one-eighth of the physicians and dentists holding clinical research positions resigned those positions and accepted other positions in DM&S in order to qualify for special pay. This rate of turnover among clinical researchers has impaired the continuity of the VA's medical research effort. In addition, the number of physicians and dentists applying for clinical research positions has declined abruptly, dropping by 30 percent for the prestigious second- and third-level research positions. Discussions with researchers in the field indicate that the exclusion from special pay was an important factor in this decline. Although at present there are more qualified new applicants than clinical research positions to fill, the decline already noted, particularly as to the most senior clinical re-

searchers, means that the VA is losing its most experienced investigators during their most productive years. Many of the VA's finest staff doctors, chiefs of services, and hospital administrators have been initially recruited through these clinical research programs. These downward trends, if continued, pose a serious threat of a setback in the VA clinical research program from which it may take years to recover.

Further clouding the research picture is the fact that the exclusion of clinical researchers from special pay comes after 2 years of real-dollar decline in the size of the VA medical research budget. Between fiscal years 1974 and 1976, the research budget grew approximately 6.6 percent, from \$91.4 million to \$97.4 million; during that same period, inflation cut the purchasing power of the research dollar by more than 30 percent, for a sizeable net *reduction* in research funds of more than 20 percent during that 2-year period.

The VA medical research program.—The research program, in short, has experienced two serious blows in the past year. The Administration had proposed in January a cut-back budget for the third year in a row (although Congress, on the recommendation of this Committee, appropriated \$4.2 million more than was requested for fiscal year 1977), and researchers have been asked to accept salaries lower by \$7,000 to \$10,000 (the amount of special pay they are required to forego because of their exclusion from the special pay program) than the amount they could earn by resigning their research positions. The result has been, according to the February 18 testimony of the VA's Assistant Chief Medical Director for Research and Education, "a significant loss of morale" among clinical researchers.

Need for continuing a strong VA research program.—A strong research program is essential to the VA health care system, for at least three reasons:

First, clinical research provides direct benefits for patients in VA hospitals. The basic biomedical and prosthetic research conducted in the VA has saved lives, reduced pain and suffering, shortened recovery times, and, in general, made hospital stays more comfortable and more successful. The VA medical research program has provided information leading to the virtual disappearance of tuberculosis as a major medical problem, has contributed to the rational drug treatment of major psychiatric illness, and is pioneering in the prevention and treatment of significant high blood pressure. Less obvious is the indirect contribution to patient care through such scientific advances as the development of radio-immunoassays for body components and the discovery of the role of glucagon, a natural antagonist of insulin, in diabetes. Overall VA research has become a major factor in improving the detection, prevention, and treatment of disease.

Furthermore, each researcher devotes a significant portion of his or her time to direct patient care, meaning that the program pays an immediate patient care dividend. It also pays a long-term patient care dividend, since 40 percent of the young VA clinical research investigators remain in DM&S as clinicians when they complete the special research career development training program, and another 40 percent continue to serve the VA as faculty members of affiliated medical schools. These clinician-investigators and their scientist colleagues

contribute to the quality of practice in VA facilities beyond their direct contribution to patient care. They create the atmosphere of questing minds and stimulating ideas that makes for progressive medical and dental care, that welcomes new advances but is cautious in evaluating them, and that is prepared for changing patterns of health care.

Second, the availability of research facilities and support money has consistently been shown to be an important factor in the recruitment and retention of physicians, and any reduction in the size or quality of the DM&S's research effort would have an immediate adverse impact on the VA's ability to recruit new physicians and retain the physicians already on board.

And third, the DM&S research program has been an important part of the affiliation process between VA hospitals and medical schools, which in turn has been one of the major contributing factors to the improvement in VA patient care during the past three decades. Slippage in the quality of the DM&S research program or in the commitment of the VA to a continuing viable program of biomedical research could jeopardize some of the VA's major academic affiliations.

It is essential that Congress continue to demonstrate its firm resolve to keep the VA research program on strong footing. Now that the fiscal year 1977 research budget has been strengthened somewhat, the Committee believes that one further step is needed to ensure that VA clinical researchers continue to be among the best in American medicine. Research positions in the Department of Medicine and Surgery have traditionally been prestigious, and have been filled by many of the ablest young physicians and dentists in the VA system. The Committee believes it is counterproductive and inequitable with respect to the medical research program and damaging to the quality of care in VA hospitals to create a financial disincentive for service as a clinical researcher by excluding researchers from eligibility for special pay.

Section 122(b) of the Committee bill therefore would amend section 4118 of title 38 to mandate the payment of special pay to all physician and dentist clinical researchers who are otherwise eligible for special pay. This would technically be done by authorizing, under subsection (a)(1) of section 4118, the payment of special pay to physicians or dentists serving in "professional or administrative positions or clinical research positions in the career development program", and then limiting the categories of physicians and dentists which may be excluded from special pay by the Chief Medical Director, under subsection (a)(3) of section 4118, to those serving in "professional and administrative positions" only—the clear result being that the Chief Medical Director is not authorized to exclude clinical researchers pursuant to this subsection (a)(3) discretionary administrative authority.

The Committee believes that this provision will make a major contribution to the restoration of morale among DM&S's clinical researchers and the continuation of the research program's vital role in the improvement of health care for all veterans.

Recruitment and Retention of Optometrists and Podiatrists

The Department of Medicine and Surgery currently employs only 8 full-time optometrists and 20 full-time podiatrists. By any conceivable

measure, these numbers are not enough to meet the demand for optometric and podiatric services in the VA health care system. Recent surveys of the DM&S patient population, for example, reveal that two-thirds of all veterans screened required some type of optometric service; because of the paucity of trained optometrists, however, less than 1 in 10 veterans received such services. Although optometrists outnumber ophthalmologists by a ratio of 2 to 1 in the United States, there are 6 full-time VA ophthalmologists for every full-time VA optometrist. This clearly implies that highly-trained ophthalmologists are performing the functions that could more effectively and inexpensively be done by optometrists. Similarly, although there are approximately three podiatrists for every 100,000 American citizens, the VA employs only 1.6 podiatrists for every 100,000 hospitalized veterans.

It is clear to the Committee that the numbers of optometrists and podiatrists employed by DM&S are substantially below the numbers indicated by the size, age, and demographic characteristics of the VA patient population.

The Committee identified several barriers which may have deterred or prevented the hiring of more optometrists and podiatrists in DM&S. Chief among these are the absence of Optometric and Podiatric Services in Central Office to coordinate recruitment and retention efforts and enhance the professional status of these personnel; the lack of continuing medical education opportunities for optometrists and podiatrists; and, most importantly, noncompetitive salaries, particularly at the mid- and advanced-career levels.

Under current law, optometrists and podiatrists are paid in accordance with the General Schedule for Federal civil service employees under title 5, United States Code. The normal starting salary for optometrists and podiatrists in the VA is \$13,482 (GS-9, step 1), with advancement to a normal career salary of \$21,113 (GS-11, step 10)—well below the average salary of \$30,000 for optometrists and \$32,000 for podiatrists in private practice. The unfortunate result of these below-average salaries has been that virtually every VA optometrist and podiatrist operates a small private practice in the evenings or on weekends in order to supplement their full-time VA salary—a circumstance which, in the Committee's view, is neither fully consistent with their professional stature as full-time members of the VA health care team nor fully conducive to high-quality patient care.

Section 113(b) of the Committee bill would amend chapter 73 of title 38 in order to enhance the recruitment and retention of optometrists and podiatrists in DM&S. Full Optometric and Podiatric Services would be created in Central Office, each headed by a Director responsible to the Chief Medical Director for the operation of his or her Service. Optometrists and podiatrists (as were physician assistants and expanded-function dental auxiliaries in the 1975 Public Law 94-123) would also be removed from the Federal civil service system under title 5, placed in the title 38 pay and personnel system, paid in accordance with a new "Clinical Podiatrist and Optometrist Schedule" to be added to section 4107 of title 38, and generally made part of the DM&S title 38 personnel system subject to the rules and procedures of chapter 73 of title 38 and implementing regulations thereunder. Under the new pay schedule, salaries would range from \$16,255 to

\$37,800, amounts substantially more in line with comparable non-VA starting and career salaries for these health professionals.

The Committee strongly believes that increased utilization of optometrists and podiatrists by DM&S would be cost-efficient and would significantly expand the scope of the health care program. The addition of optometrists and podiatrists in significant numbers would free ophthalmologists and orthopedic surgeons to perform the diagnostic and surgical procedures for which they were specially trained, and would thus result in a higher quality of health care for more veterans at a lower cost.

It is hoped that making optometrists and podiatrists part of the title 38 system will enhance their opportunities for greater professional status, more appropriate pay and working conditions, and professional and academic associations with institutions of higher learning.

Recruitment and Retention of Other Non-physician Personnel

The starting salaries of health care employees in the VA health care system (other than physicians, dentists, nurses, physician assistants, and expanded-function dental auxiliaries) are fixed by Civil Service Commission pay and job standards. These salaries are in some cases several thousand dollars below those offered employees for comparable positions in non-VA facilities. This differential between VA and non-VA starting salaries is one of the most important non-physician recruiting problems facing the Department of Medicine and Surgery.

To assist the DM&S in recruiting qualified non-physician personnel, section 113(a) of the Committee bill authorizes the Administrator of Veterans' Affairs to adjust the minimum and maximum salaries within grade, on a nationwide basis, for any category of health care personnel (except physicians) when such an adjustment is deemed necessary to aid in the recruitment of such personnel. Under the new subsection (g) to be added to section 4107 of title 38, adjustment could be ordered only for one of three specific purposes: (1) To provide pay "commensurate with competitive pay practices in the same occupation", (2) to achieve "internal alignment of rates of basic pay" in the Department of Medicine and Surgery, and (3) to attract or retain certain shortage category personnel for employment at VA health care facilities.

This provision is virtually identical to one contained in section 4(d) (3) of the Senate-passed version of legislation (S. 1711) enacted last year as Public Law 94-123, the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975. The provision was deleted from the pay comparability bill before enactment.

The following example best explains the assistance subsection (g) is designed to provide to DM&S: Assume a person who enters the VA at GS-3, or \$7,102 a year. Were the Administrator to determine (1) that, on a nationwide basis, persons in that category of personnel in non-VA facilities generally started at higher salaries than VA personnel in that category, and (2) that the salary differential had generated a recruitment problem for the VA, then he could raise the starting salary for persons in that category from \$7,192 to as much as \$9,235, the maximum salary under GS-3, step 10. The new subsection (g), in short, would give the Administrator considerable flexibility within grades, where necessary, to adjust VA starting pay and to make VA salaries more competitive with those offered by other health care facilities.

In order to allow for in-grade promotions after appropriate service, subsection (g) also allows the Administrator to permit incremental salary increases for each step comparable to those in the adjusted schedule. For example, the salary at GS-3, step 1, is \$7,102. At GS-3, step 2, it is \$7,339, an increase of \$237. If the Administrator adjusted the entry grade salary to the maximum permitted under GS-3 (\$9,235), then personnel in that category would start at that level; their first salary increase would be raised by \$237 to \$9,472. Step-to-step increments, in short, would be preserved.

The Committee believes that subsection (g) offers a valuable health care personnel recruitment tool for the Department of Medicine and Surgery.

Procedural Protections for Department of Medicine and Surgery Employees

The VA employs 136,000 health care personnel in its more than 500 health care facilities in the United States. About 100,000 of them—primarily licensed practical and vocational nurses, nursing assistants, and other nursing support personnel (32,000); medical technologists (2,200); medical technicians (8,000); pharmacists (1,200); psychologists (1,000); social workers (2,300); and therapists and therapy assistants (2,900)—are civil service employees, whose rates of pay and conditions of employment are established by Civil Service law and regulations. The remaining 36,000—primarily physicians (10,000), nurses (25,000), and dentists (1,000)—are title 38 personnel, whose rates of pay and conditions of employment are set out in chapter 73 of title 38 and the regulations and manual provisions prescribed thereunder.

Many of the statutory provisions relating to the conditions of employment of title 38 personnel date back to the original establishment of DM&S in 1946. In the succeeding 30 years, there have been many significant advances in employee relations, and legislative and judicial approaches to employee due process protections have expanded significantly. Yet chapter 73 of title 38 has not been comprehensively revised to reflect these advances, and as a result the statutory and regulatory employment rights possessed by title 38 personnel have, in certain respects, lagged considerably behind those of other Federal employees.

Section 112(a) of the Committee bill would amend chapter 73 to revise and expand the statutory procedural protections governing personnel actions with respect to all title 38 employees, including those who have not completed the prescribed period of probationary service, those serving in temporary, part-time, and intermittent positions, and those serving in training (intern or resident) positions. The amendments are designed to reflect the development of statutory and case law in this area since the current provisions in chapter 73 were enacted three decades ago, and to provide title 38 personnel with procedural protections which compare favorably to those now provided to civil service employees, and which are consistent with the special professional qualifications of such personnel and the mission of the Department of Medicine and Surgery.

Because there has been considerable misunderstanding about the scope and effect of these provisions, every effort has been made to draft the statutory language in the clearest possible terms to carry out the

Committee's intent and to explain the Committee's purposes and the legislative effect fully in this report.

The significant changes in current law that would be made by these amendments are the following:

1. *The period of probationary service would be shortened.*—There is almost universal agreement that some period of probationary service is necessary in order to allow employer and employee to evaluate the suitability of the employment relationship. Civil Service regulations (5 C.F.R., §§ 315.801, 315.802(a)) prescribe a probationary period of 1 year for career or career-conditional appointments to the competitive service, and the Federal Personnel Manual justifies the necessity for a period of probationary service in these terms:

“[The probationary period is] a final and highly significant step in the examining process. It provides the final indispensable test, that of actual performance on the job, which no preliminary testing methods can approach in validity. During the probationary period, the employee's conduct and performance in the actual duties of his position may be observed, and he may be separated from the service without undue formality if circumstances warrant. . . .

Properly used, the probationary period affords an opportunity for fostering the interest of the probationer as well as of the service. The probationary period is for most appointees the first contact with the Federal service. Intelligent and considerate treatment during the probationary period will often have a lasting effect on the career of the employee and will often save for useful and efficient Federal service employees who would otherwise be separated, or retained in positions in which they had little prospect of success.” (F.P.M., chapter 315, Subchapter 8, § 8-1.)

In contrast to the 1-year probationary period served by civil service employees, title 38 employees are required by law to serve in probationary status for three years (section 4106(b)). This longer period of probationary service has usually been justified by reference to the unique nature of the health care setting. Professional performance by a physician, dentist, or nurse requires the ability to work closely with other members of the health care team and to make correct and rapid decisions under extraordinary pressure in situations where a patient's life hangs in the balance; these are personal and professional attributes which, it is argued, cannot adequately be evaluated in a single year's time. A recent analysis (in a related context) of the distinction between hospital service and other forms of employment is found in an opinion by the Ninth United States Circuit Court of Appeals:

“. . . A hospital staff is highly interdependent, both in the sense that one doctor depends upon the professional skill of the other doctors and in the sense that the collegial nature of the body makes tolerable working relationships an absolute prerequisite to effective staff performance. The necessity for a healthy working relationship is a function of the nature of the work to be done. Incompatible workers on farms, ranches, or in certain types of factories can function reasonably well.

... Effective performance by physicians on the staff of a hospital, whose tasks require a high degree of cooperation, concentration, creativity, and the constant exercise of professional judgment, requires a greater degree of compatibility. The hospital must recognize this necessity." (*Stretten v. Wadsworth Veterans Hospital*, C.A. No. 75-2309 (9th Cir.), May 18, 1976; footnotes deleted.)

The Committee agrees that, given the distinctive personal and professional qualifications which a title 38 employee must possess, a period of initial evaluation longer than 1 year continues to be reasonable at this time. The Committee believes, however, that the 3-year probationary period provided under current law is longer than necessary and results in needless apprehension and uncertainty.

The Committee bill, therefore, would shorten the period of probationary service for title 38 employees to 2 years. This is long enough to permit careful and effective evaluation of title 38 employees, yet short enough to reduce substantially the sense of apprehension and uncertainty which frequently accompanies an extended period of conditional employment.

2. *The rights of employees who have not completed the period of probationary service and who are subject to adverse or stigmatizing personnel action would be significantly expanded.*—Under title 38 (section 4106(b)), the extent of the VA's authority in taking actions against probationary employees is unclear, as are the procedural protections which should apply under such circumstances. The statute provides a single remedy—separation from the service—for any probationer who is not found fully qualified or satisfactory, and entitles the probationer to only very minimal procedural protections in connection with reviews of performance and qualifications.

Although the courts have uniformly sustained terminations of non-tenured title 38 appointments without full, formal, adversarial procedures (*Stretten v. Wadsworth Veterans Hospital*, *supra*; *Kenneth v. Schmoll*, 482 F. 2d 90 (10 Cir. 1973); *Suess v. Pugh*, 245 F. Supp. 661 (N.D.W.Va. 1965)), the case law clearly recognizes that actions which contravene any employee's "liberty" right in his reputation or professional integrity by stigmatizing him and hence foreclosing the likelihood of future employment may not be taken without notice and an opportunity to be heard. (See *Wisconsin v. Constantineau*, 400 U.S. 433 (1971); *Board of Regents v. Roth*, 408 U.S. 564 (1972); *Goss v. Lopez*, 419 U.S. 565 (1975).) "Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him" (*Wisconsin v. Constantineau*, *supra*, at 437), or where "the State . . . impose[s] on him a stigma or other disability that foreclose[s] his freedom to take advantage of other employment opportunities" (*Board of Regents v. Roth*, *supra*, at 573), then due process under the Constitution requires that a hearing be held "to provide the person an opportunity to clear his name" (*id.*). (See *Heape v. United States Treasury*, 354 F. Supp. 396 (S.D.N.Y. 1973); *Casey v. Rouddebush and Hampton*, Unpub. D. Md., Civ. No. T74-1295, June 20, 1975.) If, however, the action "simply points up a clash of personalities and, perhaps, a difference of opinion as to how the hospital could best be run" (*Suess v. Pugh*, *supra*, at 666), then the action may be taken with only informal procedures, without affording a pro-

bationary employee (who has no due-process-protected "property" right in his job) the benefit of an adversarial hearing on the merits of the action.

It should be noted, however, that, "mere proof . . . that [an employee's] . . . record of non-retention in one job, taken alone, might make him somewhat less attractive to some other employers, would hardly establish the kind of foreclosure of opportunities amounting to a deprivation of 'liberty'." *Board of Regents v. Roth*, *supra*, at 574, fn. 14. This construction of liberty set out in *Roth* has been followed in *Russell v. Hodges*, 470 F. 2d 212, 216 (2d Cir. 1972) where the court said in referring to stigma: "The court [in the *Roth* case] made clear that by the latter phrase it meant something more than the disadvantage inevitably entailed when a person 'simply is not rehired in one job but remains as freely as before to seek another.'" It should be stressed that the issue of stigma, including the extent of foreclosure of future employment, must be determined on the facts of each individual case; and that, in questionable cases, it would seem appropriate for the agency to resolve any doubt in favor of providing a full, trial-type hearing prior to the effectuation of action against a probationary employee.

In order to embody the above state of the case law as to probationary employees, to forestall costly future litigation, and to provide additional protections against stigmatizing personnel actions, the Committee bill would amend existing law in three important respects.

First, the Committee bill would guarantee substantial procedural rights for any probationer against whom action is proposed to be taken. Such probationer would be entitled, before any action is taken, to a written statement of reasons for the proposed action, an opportunity to reply (orally, or in writing, or both), assistance by a personally-selected representative in the preparation of a reply, and review, as a matter of right, by the Chief Medical Director. None of these protections is currently provided under chapter 73 or VA regulations.

Second, the Committee bill would require a full, trial-type hearing for any probationer subject to an adverse personnel action on grounds constituting misconduct or which would result in stigmatizing the employee. This represents a codification of rights established by the case law. (It would, in fact, expand somewhat the protections afforded to employees, since it would include "misconduct" as a ground requiring a hearing; the case law has established that a hearing is required only when personnel action would have a stigmatizing effect on the employee, as would be the case with many but not all charges of misconduct. The Committee believes that the administrative process would be simplified by affording a full hearing in both of these contexts, thereby eliminating costly and difficult legal arguments, on a case-by-case basis, as to whether a particular charge of misconduct is or is not stigmatizing.)

Third, the Committee bill would permit action short of termination of the appointment to be taken against probationers whose competence or performance is not found fully satisfactory by a specially-constituted reviewing board. The reference in present law to the single sanction of separation has raised a doubt about the agency's authority

to take lesser actions, such as warning, counseling, or reassignment. Such a doubt could confront the agency with the unfortunate choice between condoning the less than acceptable performance or resorting to the drastic sanction of termination. By authorizing a more flexible response in such situations, the Committee bill would enhance the likelihood that title 38 employees would be given a second chance when circumstances permit.

Fourth, the Committee bill specifies that only when the review board recommends that action be taken (such as termination of the probationary appointment, reassignment, warning, or other such non-disciplinary action) against the probationer, may any such action be taken by the Department of Medicine and Surgery. If the board does not recommend that such action be taken against a particular probationer after reviewing his or her performance record, that would be the agency's final decision on the matter, and would not be subject to modification, reversal, or review by the Chief Medical Director or any other agency official or board.

3. The statutory rights of all title 38 employees against whom disciplinary action is proposed would be revised and expanded beyond the substantial protections already afforded them.—Under current law (section 4110), disciplinary action is proposed by specifically constituted disciplinary boards. Employees made to appear before such boards are afforded by the statute the right to prior notice and fair hearing, the right to be represented by counsel before the board, and the right to appeal adverse board decisions to the Administrator, all before final action is taken. These rights remain intact under the Committee bill.

By contrast, a Civil Service employee is entitled to only limited procedural protections prior to the taking of an adverse action under chapter 75 of title 5, United States Code, including (under section 7501(b)) only notice of the action; a copy of the charges with reasons in writing for the proposed action; opportunity to file a written answer to the charges, to file affidavits in support of the answer, and to have a reasonable time in which to prepare the answer; and a written agency decision at the earliest practical date. The right to a hearing, let alone a prior hearing, is not guaranteed, and is provided only if specified in the regulations of the employing agency.

Under section 112(a)(2) of the Committee bill, existing section 4110 of title 38 would be extensively rewritten to achieve several important results, while securing all rights presently afforded by the section.

First, the cause for which disciplinary action could be taken against title 38 employees would be made to conform to the cause for which adverse action may be taken against Civil Service employees—"such cause as will promote the efficiency of the service" (5 U.S.C. 7501(a)). A well-developed body of case law has defined and given substance to this statutory term. In the words of the Federal Personnel Manual:

A just and substantial cause is necessary for an adverse action and the action must be determined on the merits of each individual case. . . . In every case the agency's action should be based on the conclusion that the adverse action is warranted (i.e., the agency has a just cause for the action taken) and that the agency can establish, or 'prove,' the facts

which support its reason for action. (F.P.M. Supplement 752-1, Subchapter S3, § S3-1.b (July 2, 1974).)

The Committee believes that two purposes are served by the proposed adoption in the title 38 context of the "cause" standard from title 5: Equity, through the application of the same standard to all VA health care employees, and greater precision, through uniform use of a term with a well-established common law meaning.

The Committee emphasizes that the new ground for taking disciplinary action against title 38 employees is meant to clarify the existing grounds, not to supplement or broaden them. In the Committee's view, the three grounds for disciplinary action under current law—inaptitude, inefficiency (which has been construed by the VA to mean "ineffectiveness"), and misconduct—may constitute legitimate "cause" for disciplinary action but only insofar as it is found that such action would "promote the efficiency of the service". Thus, a clear job-related context is established for any disciplinary action proposed against a title 38 employee. By changing the performance reference, as a permissible cause which would promote the efficiency of the service, from "inefficiency" to "ineffectiveness", the Committee seeks merely to choose a more apt term and to codify agency regulations in this respect.

A second result achieved by the rewritten section 4110 would be a considerable broadening of the number of title 38 employees to whom the full, prior, trial-type hearing protections of the section would apply in whole or in part. Under current law and regulations, the section applies to only those personnel appointed to positions in DM&S under section 4104(1) of title 38 (under current law, physicians, dentists, nurses, physician assistants, and expanded-duty dental auxiliaries) who have completed their 3-year periods of probationary service—about 20,000 of the 31,500 permanent, full-time title 38 employees (plus an undetermined number who will acquire these protections earlier after the 2-year probationary period provided for in the committee bill). Under the revised section 4110 in the Committee bill, permanent title 38 employees would continue to be protected against all forms of summary disciplinary action, while similar protection would be provided for the first time to probationers, house staff members, and temporary full-time, part-time, and intermittent title 38 employees charged with misconduct or other charges which would stigmatize them. Approximately 27,400 title 38 employees (11,500 probationers, 800 interns, 6,500 residents, and 8,600 temporary employees) would thus be made eligible for the protections in section 4110.

TABLE 5.—TITLE 38 EMPLOYMENT BY FULL TIME, PART TIME, AND PROBATIONARY STATUS, FISCAL YEAR 1976

	Full-time probationary	Full-time non- probationary	Part time	Total
Physicians.....	1,480	4,355	3,225	9,060
Dentists.....	262	590	16	868
Nurses.....	9,736	14,993	1,672	26,401
Physician assistants.....	1,149		53	202
Total.....	2 11,478	2 19,878	4,966	36,531

¹ Not broken down into probationary and nonprobationary status.

² Exclusive of physician assistants.

Note: Figures on full-time and part-time employment are as of June 30, 1976; figures on probationary employment are as of Feb. 14, 1976. All data are supplied by the Department of Medicine and Surgery.

The Committee stresses that the protections afforded to the non-full-time DM&S employees in the case of proposed disciplinary action on the basis of charges of misconduct or other reasons which would stigmatize the employee in question are not intended in any way to restrict the right of the agency to terminate or not renew an appointment of such employee for other reasons. In other words, where the employee's appointment is terminated or not renewed with no reference to an act of misconduct or a reason which would stigmatize the employee, no section 4110 hearing would be required by the Committee bill.

Third, the rewritten section 4110 in the Committee bill makes several changes in the statutory provisions for selection and composition of disciplinary boards. For the most part, these changes codify rules and procedures in existing VA regulations and manual provisions, and serve merely to reflect statutorily the procedural refinements adopted administratively since the statute's enactment 30 years ago. One statutory change adds a requirement that a majority of the board be of the same profession as the employee charged (a requirement now imposed by manual provision, MY-5, part II, chapter 8, section C, paragraph 3.a.; the statute (section 4110(a)) currently imposes this requirement only with regard to dentists). Another specifies that appointment of the chairman of the board shall be made by the Chief Medical Director, and election of the board secretary by a majority of the board members (under current law (section 4110(b)), the Administrator (delegated to the chief medical director by regulation) appoints both the chairman and secretary). The Committee bill also adds a requirement that the board members be of comparable or higher grade—under section 4103 or 4107—than the employee charged (under current law (section 4110(a)), board members shall be "senior in grade").

A fourth and significant result of the Committee bill's rewritten version of section 4110 is to expand the statutory rights of employees appearing before a disciplinary board, and to revise the procedures under which the agency reviews the recommendations of the board. Under the revised section 4110(d), an employee answering to charges before a disciplinary board would statutorily be entitled to the following protections before any disciplinary action is taken: Specification of charges; a full, trial-type hearing with opportunity to produce and cross-examine witnesses at the hearing; and representation by a person of the employee's choice throughout the disciplinary board proceeding. Of these rights, current law (section 4110(c)) guarantees only the right to counsel, although all the other procedural rights are provided by regulation (MP-5, part II, chapter 8, section C, paragraph 4.c.).

Existing section 4110(d) as supplemented by VA regulations (MP-5, part II, chapter 8, section C, paragraph 5), defines the procedures under which the agency reviews and acts upon the recommendations of a disciplinary board. Under the Committee bill, a revised section 4110(e) would be substituted for section 4110(d), and would make two substantive changes in the statute.

First, the revised provision would require that the employee be provided with a written explanation for any disagreement with, exception to, or modification of any finding or recommendation of the disciplinary board on any charge. The Committee regards the absence

of such a requirement as a serious defect of current law and regulation, and considers its addition to section 4110 a most significant procedural guarantee. A written statement of reasons for any agency action is widely recognized by judicial and academic authorities as a significant administrative mechanism which "tends to require the agency to focus on the values served by its decision, hence releasing the clutch of unconscious preference and irrelevant prejudice." (*Childs v. United States Board of Parole*, 511 F. 2d 1270, 1287 (D.C. Cir. 1974) (Leventhal, J., concurring)). Professor Kenneth Davis, a leading authority on administrative procedure, has written :

The reasons [for such a requirement] have to do with facilitating judicial review, . . . assuring more careful administrative consideration, helping parties plan their cases for [administrative] rehearings and judicial review, and keeping agencies within their jurisdiction. (*Administrative Law Text* (3d ed. 1972), ¶16.03 at p. 320)

The Committee is also firmly convinced that the findings or recommendations for disciplinary action of a disciplinary board on any charge found to be sustained by the board should not be altered without a full written explanation being provided to the charged employee. The effect of requiring the agency to justify in writing any deviation from the findings and recommendations of the disciplinary board will be, the Committee believes, to afford a strong presumption of correctness to the findings and recommendations of the disciplinary board.

It should be noted in this regard that the Committee bill retains the requirement from present law that only when the disciplinary board sustains a charge against the employee may the reviewing officer, here the Chief Medical Director, modify any board recommendation for disciplinary action; nor may the Chief Medical Director take exception to any board finding except with respect to a sustained charge. If the board totally exonerates the employee on a charge, then the Chief Medical Director must accept the board's decision as his own on that charge. The bill clarifies the Chief Medical Director's authority to take exception to board findings of fact underlying a charge sustained by the board.

The second substantive change that would be made by the Committee bill in the review procedure is the substitution in the statute of the Chief Medical Director for the Administrator of Veterans' Affairs as the reviewing officer. Under current law, a disciplinary board can make its recommendations either to the Administrator directly (section 4110(d)), or, if the Administrator chooses to delegate that authority to the Chief Medical Director, to the Chief Medical Director (section 4110(e)). (Under VA regulations (MP-5, part II, chapter 8, section C, paragraph 5.b.), the Administrator has delegated primary decisionmaking authority to the Chief Medical Director; if the disciplinary action recommended by the Chief Medical Director is more severe than an admonishment—in other words, a reprimand, suspension, demotion, or separation—then the employee may appeal as a matter of right to the Administrator (paragraph 5.c).) In practice, the Chief Medical Director's decision has operated as the final agency decision, since the Administrator virtually always ratifies the decision of the Chief Medical Director. Legally, however, such an employee who

seeks injunctive or other judicial relief against an agency disciplinary action must first file an appeal with the Administrator in order to satisfy the threshold jurisdictional requirement of exhaustion of administrative remedies. This final administrative appeal may take months to resolve; will seldom, if ever, serve any substantive purpose, since the Administrator will almost always approve the Chief Medical Director's findings with no modification; and thus unnecessarily delays the employee's access to the courts.

The Committee bill would, first of all, codify the VA regulation making the Chief Medical Director the primary decisionmaker, so that the Chief Medical Director would exercise that authority statutorily rather than through delegation from the Administrator. The Committee bill would also make the Chief Medical Director's decision the final agency decision, eliminating the appeal to the Administrator. By removing this ineffective and time-consuming step from the review process, the Committee intends to facilitate judicial review of agency decisions (for employees who desire such review) by ensuring that access to the courts is not delayed or precluded by an employee's failure to exhaust all administrative remedies. In this regard, the comments of Chief Medical Director John D. Chase in a recent letter to the Chairman of this Committee's Subcommittee on Health and Hospitals are appropriate:

. . . [T]he interest of both the employee and the agency in having disciplinary actions resolved expeditiously is more compelling than is the preservation of a step in the administrative process that has seldom been useful to the employee except for the purpose of exhausting his administrative remedies prior to filing an action in the courts. The decision to delete this step was made only after consideration was given to the frequency of reversal of decisions of the Chief Medical Director by the Administrator. The facts are that such reversals of decisions of my predecessors or of my decisions have been extremely rare. (Letter from Chief Medical Director Chase to Senator Alan Cranston, July 29, 1976, p. 1.)

Finally, the Committee believes that the Chief Medical Director should properly, as the head of the Department of Medicine and Surgery and as part of his statutory responsibility to manage the day-to-day affairs of the Department, make the final agency decision on such critical DM&S personnel actions.

4. The agency's authority to reassign title 38 employees for disciplinary or non-disciplinary reasons would be limited by statute; and the procedural rights of employees whom the agency proposes to reassign would be substantially broadened.

Federal employees are generally subject to reassignment between duty stations as a condition of employment. Civil Service regulations (5 C.F.R. 335.102), for example, authorize employee reassignment as part of an agency's internal placement authority, and a series of recent court cases—*Pauley v. United States*, 419 F. 2d 1061 (7th Cir. 1969); *Burton v. United States*, 404 F. 2d 365 (Ct. Cl. 1968); *Urbina v. U.S.* 180 Ct. Cl. 194 (1967); *Madison v. United States*, 174 Ct. Cl. 985 (1966); *Kletschka v. Driver*, 411 F. 2d 436 (2d Cir. 1969) (pas-

sim)—has clearly established that Federal agencies may reassign their employees between stations, and that employees are obliged to accept such reassignments as a condition of their employment in the Federal service, or be subject to separation for refusal to do so.

Two Forms of Reassignments

Reassignments can take either of two forms. First, employees may be reassigned because their services are needed at another duty station. These reassignments, known generically as reassignments "for the good of the service", may be ordered under VA manual provisions whenever "necessary to meet the needs of the medical program" (MP-5, part II, chapter 9, paragraph 9). They are nondisciplinary in nature. Court cases have uniformly sustained the authority of Federal agencies to order such nondisciplinary reassignments when necessary to promote efficiency and good management: "We recognize," the United States Court of Claims has held, "that agencies have power to effect geographical reassignment of employees, except as self-limited." (*Burton v. United States*, 404 F. 2d 365 (Ct. Cl. 1968).)

The other kind of reassignment is the so-called "disciplinary reassignment", which results in reduction in pay, grade, or relative standing or which is proposed for the purpose of disciplining an employee for unsatisfactory job performance, misconduct, or for "such cause as will promote the efficiency of the service".

The distinction between the two kinds of reassignments is an important one, because the procedural protections which have been afforded to employees whom an agency proposes to reassign are quite different in each of these contexts. A series of recent cases—*Kletschka v. Driver*, 411 F. 2d 436 (2d Cir. 1969); *Gilbert v. Johnson*, Civ. No. 16424 (N.D. Ga., June 16, 1972), subsequent court order appealed on other grounds and vacated and remanded, 490 F. 2d 827 (5th Cir. 1974), on remand, Civ. No. 16424 (N.D. Ga., July 2, 1976); *Motto v. General Services Administration*, 335 F. Supp. 694 (E.D. La. 1971)—has held that a Federal agency employee may not be subjected to a disciplinary reassignment unless the agency affords the employee a hearing and all the procedural rights associated with any proposed disciplinary action. In other words, any agency may not avoid affording the procedural safeguards attaching to disciplinary actions by cloaking a reassignment, intended to discipline an employee, in non-disciplinary terms. An employee who is reassigned for a legitimate good-of-the-service reason, by contrast, must (unless agency titled only to the procedural protections provided in agency regulations. See *Kletschka*, *supra*; *Burton*, *supra*).

Civil Service regulations distinguish between types of reassignment in terms of the different procedural rights which must be afforded in each case. Under Civil Service regulations (5 C.F.R. chapter 771), a civil service employee whom the employing agency proposes to reassign for the good of the service may file a formal grievance with the agency to protest the reassignment. The Civil Service grievance process, while not guaranteeing a hearing on the reassignment, affords the employee several procedural protections, such as specification of the reasons for the reassignment and resolution of the grievance by a fair, impartial, and objective examiner. If, however, the reassignment is disciplinary in nature or results in reduction in rank or salary the Civil Service law would classify the reassignment as an adverse action

which entitles the employee to a considerable range of procedural protections, including advance written notice of reasons for the action, the right to answer in writing and in person, and the right to appeal an adverse action, after it is taken, to the Civil Service Commission (FPM Supplement 752-1, Subchapter S1; 5 C.F.R. 752.302.).

Title 38 regulations, on the other hand, do not distinguish between the two kinds of reassignments. The VA's reassignment authority is contained in MP-5, part II, chapter 9, paragraph 9, which reads in its entirety as follows:

9. FAILURE TO ACCEPT TRANSFER

Physicians, dentists, or nurses are expected to accept transfers as a part of their employment obligations. Failure to accept a transfer determined necessary to meet the needs of the medical program may result in separation upon decision of the Chief Medical Director. When it has been decided that the employee is to be separated, the field station head will inform him in writing of this decision. The employee will be given a period of notice of not less than 30 calendar days.

In the Committee's view, this regulation, adopted in 1964 and not revised since then, is defective in three respects. First, it does not distinguish between reassignments for the good of the service and disciplinary reassignments. Second, it very clearly does not reflect recent case law defining the due process rights of Federal employees who are ordered reassigned for disciplinary reasons. And third, it gives the agency virtually unfettered power to order reassignments for the good of the service, and affords title 38 employees no procedural rights with which to challenge such a reassignment within the agency; the grievance process may not be invoked because, under VA regulations now in effect (MP-5, part II, chapter 8, section B, paragraph 4.h.), a reassignment for the good of the service is not subject to adjudication by grievance.

In short, title 38 employees lag considerably behind other Federal civilian employees in the protections provided under current law and regulations against the arbitrary exercise of the reassignment authority. The Committee believes that the VA's 36,000 title 38 employees deserve at least the same protections against arbitrary reassignment as the 100,000 civil service employees in VA health care facilities with whom they work. A major purpose of the Committee bill, therefore, is to give title 38 employees significant new protections against the arbitrary exercise of the agency's authority to reassign for disciplinary purposes.

Disciplinary Reassignments

Under a new section 4110(f) which would be added to title 38 by the Committee bill, any title 38 employee whom the VA proposes to reassign for an asserted disciplinary reason, or proposes to reassign in such a way as to produce reduction in rank, grade, or standing, would be statutorily entitled, prior to the taking of any action, to a full, trial-type hearing at which the agency would bear the burden of proving the validity of disciplinary charges in order to justify the proposed reassignment action. The employee would be entitled to specification of the charges, the opportunity to produce and cross-examine witnesses,

and representation by personally-selected counsel. As with any proposed disciplinary action, the reassignment would be stayed pending the outcome of the hearing proceeding and the internal agency review process.

The Committee bill thus embodies all of the protections guaranteed by applicable case law to guard against arbitrarily-ordered disciplinary or demotional reassignments, and also requires many protections—most notably the right to a full hearing prior to the proposed reassignment—which are not afforded as a matter of statutory or regulatory right to civil service employees under adverse action procedures.

Reassignments for the Good of the Service

The Committee bill also provides significant new protections for employees whom the VA proposes to reassign "for the good of the service". Under the new section 4110(f), any title 38 employee ordered so reassigned would be entitled, as a matter of statutory right, to file a grievance with the VA whenever he or she suspects that a reassignment ostensibly "for the good of the service" has actually been proposed for disciplinary reasons. Applicable VA procedures entitle an employee filing a grievance to receive, upon request, a full range of procedural rights and protections, all of which the employee could invoke once such a reassignment is deemed a grievable employment issue. The ultimate grievance protection under VA regulations would be the right to a full hearing on the nature of the reassignment if less formal procedures fail to produce a resolution satisfactory to the employee. In a VA grievance hearing, the employee has the right to present his or her case to an impartial hearing committee, to be represented by counsel, to cross-examine witnesses, and to appeal an adverse finding to the Chief Medical Director.

None of these procedural rights is provided under current law or DM&S regulation because under VA manual provisions a reassignment is not a grievable issue. By extending to title 38 employees whose reassignments have been proposed "for the good of the service" at least those protections presently afforded in the grievance process, the Committee bill is providing a protection which is similar to a procedure already available, under Civil Service regulations, to the majority of VA health care personnel and other Federal civilian employees.

As an added protection, the Committee bill would require that a proposed reassignment "for the good of the service" be held in abeyance pending resolution of the grievance process, so that a title 38 employee could not actually be reassigned until the final agency appeal is exhausted. This protection is not provided to other Federal employees under Civil Service regulations. If, under the new section 4110(f), the agency sustains an employee's grievance and rules that a reassignment purportedly "for the good of the service" is in fact disciplinary in nature, then the employee would be entitled to a full hearing on charges which would justify the proposed disciplinary reassignment; since the disciplinary reassignment would clearly be stayed pending the outcome of the hearing, all procedures preceding the hearing must be afforded prior to the taking of any action.

The procedural protections provided under the Committee bill to title 38 employees whom the VA proposes to reassign "for the good

of the service" are predicated in large part on the protections now available in other contexts under the VA's grievance process (MP-5, part II, chapter 8, sections B ("Grievances") and C ("Hearings")). Under the new section 4110(f), employees would be entitled to "the procedures prescribed by the Administrator to determine employee grievances." In the Committee's view, this provision incorporating, as a matter of law with respect to such proposed reassignments, those protections now afforded in the present grievance procedures, would prohibit any administrative changes in the VA's manual provision defining grievance procedures which could have an adverse impact on the rights of a title 38 employee whom the agency proposes to reassign "for the good of the service". If therefore, the agency proposes *any* change in the grievance procedure as it would apply in such circumstances to such proposed reassignments—whether designed to clarify an employee's existing rights under the grievance process or to provide new rights or protections—such proposed change should be published for comment from affected employee groups and the public and be fully discussed with the Committee prior to implementation to ensure that no rights are lost.

"For the Good of the Service" Defined

The term "reassignment for the good of the service" as used in the Committee bill and in this report refers to reassignments ordered under either of two circumstances, and two circumstances only. First, an employee may be reassigned "for the good of the service" when, because of a personnel shortage or an unmet demand for a particular patient service, the employee's services are needed at another duty station or in another capacity at the same duty station.

The Committee notes that temporary reassignment may be ordered to meet emergency situations, and that employees detailed temporarily are entitled to return to their permanent duty station when the detail period expires. The Committee expects that the agency's authority to reassign employees permanently "for the good of the service" will be circumscribed by the availability of the less-obtrusive temporary detail authority, and that permanent reassignment will be ordered only when temporary details cannot resolve a placement problem satisfactorily. The Committee also notes that a permanent reassignment must be devoid of any element of punishment or discipline; that, if such an element is present, the reassignment must be preceded by a full hearing and associated procedural rights; and that, if the employee suspects that a disciplinary or punitive intent underlies the agency's reassignment decision, he or she is entitled to file a grievance and have the reassignment stayed pending the resolution of the full grievance procedure, as described above.

The second circumstance pursuant to which an employee may be reassigned "for the good of the service" would be one where the employee, for reasons related not to his or her competence or job performance, but to personality and ability to get along with fellow workers, simply is unable to function effectively at the assigned duty station. In a personnel system as large as the VA's, situations will inevitably arise where one employee cannot get along with one or more fellow employees for personal reasons which neither reflect adversely on that employee's professional competence nor reduce in any way his or her

potential contribution to the mission of the Department of Medicine and Surgery. Frequently, new duties or a fresh start at another facility can reduce unpleasant friction between employees before it can have an adverse effect on patient care, and can restore the usefulness of an employee whose contribution has been impaired because of strained relations at a former duty station.

The Committee firmly believes that the effective functioning of the VA medical and hospital program is served by providing a non-disciplinary method of resolving these occasional personality problems. The Committee recognizes that decisions in an area as sensitive as this can be extremely difficult, and that the line between disciplinary and non-disciplinary reassignments in this area is not always perceptible. Nevertheless, the Committee has concluded that providing a non-stigmatizing, non-disciplinary method of resolution is preferable to the two alternatives—either permitting the personality conflict to fester to the point where staff performance and patient care are badly damaged, or requiring a disciplinary proceeding and a formal disciplinary action in each such case. The Committee reiterates that all the protections of the grievance process would, under the Committee bill, be available to any employee who suspected that a reassignment proposed for personality reasons was in fact disciplinary or punitive in nature and that such a reassignment would be stayed by the filing of a grievance and could not be effectuated until the full agency process had been completed in connection with such proposed reassignment.

Only in the two circumstances described above—when an employee's services are needed at another duty station to resolve a personnel shortage, or when personality friction threatens to reduce an employee's effectiveness—would the VA be permitted to reassign a title 38 employee "for the good of the service", without benefit of a prior, full hearing on the ground for the reassignment—and even in those situations, the employee would be entitled to the grievance process hearing and other rights to try to demonstrate that the proposed reassignment was in fact disciplinary in nature. In all other circumstances when DM&S proposes to reassign a title 38 employee, the employee would be entitled to the disciplinary board procedural protections described in the new section 4110, and such an employee could be reassigned only if, after the full hearing and review by the Chief Medical Director, the agency determined that the reassignment was for "such cause as will promote the efficiency of the service" as that phrase has been strictly construed by the courts.

The Committee also intends that the timing of any proposed reassignments must take fully into account the personal needs and situation of the affected employee. Where reassignment is proposed to fill an emergency need at another duty station, every effort should be made to find an employee who will voluntarily accept such a reassignment before such a reassignment—even a temporary one—is directed for an unwilling employee. And in the case of personality disputes, all actions short of reassignment, such as counseling, transfer within the duty station, and so forth, should be exhausted before resort to reassignment to another duty station is made, and every effort should be made to ensure that the new arrangement is as compatible as possible with the needs and preferences of the employee.

Finally, the Committee stresses that the provisions in the Committee bill relating to reassignment of title 38 employees do not create any new authority to reassign employees. Rather, the provisions sharply limit the agency's summary authority to order reassignments by providing employees with concrete statutory protections against the arbitrary or unjustified exercise of that authority; conform the rights of title 38 employees to those possessed by civil service employees, and in some instances provide additional rights; and codify protections now embodied in case law and regulations, so that title 38 reflects accurately the rights of employees and the duties of the agency.

Compensated Work-Therapy Program

Section 107 of the Committee bill would revise section 618 of title 38 to clarify the statutory authority for the compensated work-therapy program that is currently ongoing in the VA. Such a program has existed in some form in the VA since the late 1930's, and is now carried out as part of chapter 17 medical care and the VA's general contract authority in section 213. Approximately 2,000 patients are now engaged in the program at 52 VA health care facilities.

As the program is now administered, work projects are procured from various organizations. VA patients perform work on the projects as a medically therapeutic activity, and are supervised by VA medical personnel. Participating patients are paid from the proceeds of the contract.

(The compensated work-therapy program should be distinguished from the incentive therapy program authorized in present section 618. Patients who work in the incentive therapy program are paid from appropriated funds, and generally perform tasks of a custodial or clerical nature at VA health care facilities. The amendment of section 618 contained in section 107 of the Committee bill will not affect the incentive therapy program.)

Over the years, the compensated work-therapy program has become more complex and grown in such a way as to raise some questions about the legal authority for the program. The Committee intends that section 107 would provide any necessary clarification of the VA's authority to conduct the compensated work-therapy program as it now exists, and fully expects that existing compensated work-therapy projects will be continued in their present form.

Under the revised section 618, the VA would be required to pay participants in the program at rates of pay not less than those specified in the Fair Labor Standards Act and the regulations prescribed thereunder, including the provisions for a reduced minimum wage for handicapped workers as established by the Secretary of Labor pursuant to section 14(c) (2) of the Fair Labor Standards Act (29 U.S.C. 214(c) (2)).

There is no intention to change the status under law of the poppy-assemblage programs carried out by patients in various VA health care facilities in cooperation with veterans' service organizations.

The Committee is also cognizant of the bidding practices currently governing the VA in the procurement of work projects for compensated work-therapy programs. Under DM&S guidelines, all compensated work-therapy programs are now required to bid competitively

for such projects, utilizing commonly accepted practices in accordance with guidelines recommended by the Association of Rehabilitation Facilities. The clarification of authority in section 107 of the bill is provided with the explicit understanding that such bidding practices will be continued in full force and effect in the VA. These bidding practices are essential for two reasons: First, to avoid unfair competition with sheltered workshops and other organizations which might compete with the VA for contract work projects; and, second, to avoid subsidization of organizations furnishing work projects resulting from uncompetitively low bids under which such organizations would receive an unfair advantage. Unless a fair overhead is included in VA compensated work-therapy bids both the above undesirable results could occur. Failure to include such an overhead factor could be a particular problem because overhead expenses in VA medical programs are, to a large extent, continuing fixed costs which are present whether or not a compensated work-therapy program exists.

The Committee intends, therefore, that a factor equivalent to competitive overhead rates would continue to be included in the competitive bidding process for all compensated work-therapy programs.

Finally, the Committee wishes to highlight and explain the addition of the words "or credited to" in new subsection (c) (2) of section 618 of title 38, as added by this section of the Committee bill. As introduced, S. 2908 provided, in new subsection (c) (2), that all funds received by the VA, including proceeds from the sale of goods or services by non-profit corporations, should be "deposited in" the special revolving fund established for such purpose in new subsection (c) (1) of section 618. This provision raised concerns with the managing officers of several of the existing non-profit corporations, who suggested in written communications to the Committee that no purpose would be served by requiring the non-profit corporations to pay all proceeds into the revolving fund and then withdraw from the fund the amounts necessary to cover approved overhead and other operating expenses. The operating efficiency of the non-profit corporations, the managers maintained, would be adversely affected unless provision were made in the Committee bill for direct application of a proportion of the proceeds to operating expenses without the necessity for an expensive and time-consuming detour through the revolving fund.

The Committee believes there is merit to this contention, and has therefore amended new subsection (c) (2) in the reported version of the bill to provide that funds received through the sale of goods or services must be "deposited in or credited to" the revolving fund. By this language, the Committee intends to permit non-profit corporations to apply an approved proportion of proceeds directly to operating expenses. The Committee envisions that the non-profit corporations and the VA will agree upon procedures and arrangements for achieving this result; for example, the non-profit corporation could prepare a payroll and expenses budget for submission to and approval by the VA, showing an amount to be deducted monthly from total proceeds before the remainder of the proceeds is deposited in the revolving fund. The monthly deduction could cover operating (including permanent, nonpatient employee payroll) expenses, and be credited to, but not deposited in, the revolving fund after the VA has approved the amount.

The Committee believes that such a procedure would be a sensible way to permit continuation of the excellent contributions which many of the existing non-profit corporations have made. In this connection, one of the principal goals of this revision of section 618 is to provide explicit authority for these non-profit corporations to continue their fine work under appropriate VA fiscal control, and the Committee expects DM&S to develop the necessary procedures to see that this goal is achieved.

Protection of Patient Rights

A significant feature of the Committee bill is its addition of a new subchapter, entitled "Protection of Patient Rights", at the end of chapter 73 of title 38. The new subchapter incorporates into title 38 standards for ensuring appropriate informed consent of all patients and research subjects in VA facilities and provisions (already largely included in other laws), guaranteeing the confidentiality of certain sensitive patient medical records, and proscribing discrimination against alcohol and drug abusers in admission to VA facilities.

Informed Consent

With respect to informed consent, the Committee bill adds, as part of the new subchapter on patient rights, a new section 4131. Under the new section, the Administrator would be required to prescribe regulatory procedures to ensure that no medical or prosthetic research is carried out on any subject in a VA health care facility, and—to the maximum extent practicable—no patient care is furnished under the provisions of title 38, without the full and informed consent of the subject-patient.

Like many issues on the interface between law and medicine, "informed consent" is an extremely difficult and provocative problem. Insofar as research is concerned, it is very clear that the VA is under an obligation to explain to the research subject all known potential risks to which he or she will be exposed, and that the subject should consent to any procedure before that procedure is performed. But there are undefined areas as to what constitutes "consent", how "informed" it must be, and how thorough the researcher's explanation must be. These are legal as well as medical issues.

The purpose of the informed consent requirement in the Committee bill is to ensure that the VA, in consultation with appropriate medical and legal sources, develops regulations to protect the patient's right to decide, voluntarily, what is in his or her best "health" interest, weighing the risks involved against the potential gains. It is not altogether clear that generally applicable regulations or forms currently guide the VA in the extremely delicate area of obtaining the informed consent of patients and research subjects prior to the provision of medical care. Although VA regulations (M-2, part XIV, chapter 1, § 1.02 ("Requirements for Surgery")) require that patients consent to the performance of surgical procedures, it is not clear on the face of the regulation how broadly its protections apply: for example, a circular of the Department of Medicine and Surgery dated January 6, 1976, containing guidelines for informed consent procedures in cardiac catheterization laboratories suggests that there were not sufficiently detailed guidelines prior to that date, despite the obvious

risks and high relative morbidity rate for the cardiac catheterization procedure. The Committee is concerned that there may be other such situations.

Furthermore, although internal VA memoranda (Interim Issue 10-75-8, March 10, 1975; circular 10-75-121, June 19, 1975) establish comprehensive procedures for obtaining the informed consent of research subjects, the Committee believes that patient rights in this critical area—recently the subject of extensive hearings before other Committees and studied as to the VA's psychosurgery program in joint hearings held by the Health and Hospitals Subcommittee and the Health Subcommittee of the Labor and Public Welfare Committee on June 18, 1973—should have an underlying statutory basis rather than depending only on expressions of internal agency policy.

The Committee bill therefore provides a statutory basis for regulations governing informed consent procedures and subsequent Congressional oversight activities. As described more fully below, the bill also requires that the VA be generally guided in prescribing informed consent and human experimentation guidelines by those adopted by HEW based on the forthcoming recommendations of the National Commission for the Protection of Human Subjects.

Confidentiality of Certain Medical Records

With respect to the confidentiality of sensitive medical records, the Committee bill includes, as part of the subchapter on patient rights, a new section 4132 protecting the confidentiality of medical records maintained by DM&S in connection with drug abuse, alcoholism, and sickle cell anemia treatment, rehabilitation, training, and research programs.

Persons suffering from alcoholism or drug addiction are often fearful of social stigmatization or run-ins with law enforcement officials. Prior to 1972, when Public Law 92-255 was enacted to render confidential under certain prescribed conditions the medical records of drug abuse patients in any Federal or Federally-assisted program, large numbers of addicted veterans who might otherwise have sought VA treatment probably did not do so, for fear that the fact of their disability and confidential information revealed during treatment would be available for easy distribution and circulation.

On the other hand, the applicability to the VA of section 408 of Public Law 92-255 created several problems for the VA—problems which were described in considerable detail on pages 36 to 40 of the Senate Report—No. 93-56—on S. 284, the Veterans' Drug and Alcohol Treatment and Rehabilitation Act of 1973, dated March 2, 1973.

The particular problems of confidentiality of records in the VA health care system can best be handled by placing the applicable provisions in title 38. Accordingly, the new section 4132 proposed in the bill would ensure the general confidentiality of sensitive medical records by establishing stiff civil sanctions for unauthorized disclosure of information, while at the same time meeting the legitimate needs for disclosure under certain, narrowly drawn conditions.

In every substantive respect except one, the new section follows present section 408 of Public Law 92-255. Because of the great extent of VA survivorship benefits which may depend to some extent on VA health care records, the new section, unlike section 408 of Public Law 92-255 (under which a court order would be required) permits dis-

closure, under carefully circumscribed conditions, to a deceased veteran's survivor or personal representative in connection with obtaining survivorship benefits. (The authorizing Committees dealing with that Public Law have been consulted and raised no objection to this exception given the special veterans' survivorship benefits situation.)

The same protection and procedures are provided with respect to alcoholism and alcohol abuse treatment, rehabilitation, education, training, and research patient records, derived from the generally applicable provisions in section 333 of the Comprehensive Alcohol Abuse and Alcoholism Act of 1970.

The same protection and procedures are made applicable with respect to sickle cell anemia treatment, rehabilitation, education, training, and research patient records pursuant to present subchapter VI of chapter 17. These more protective provisions would replace those in section 653(b) under which patient records could be released to other than medical personnel. The Committee believes that veterans who have been screened or treated by the VA for sickle cell trait or sickle cell disease should not be subject to having their medical records released to anyone other than medical personnel for emergency treatment, anonymously for bona fide research or program evaluation or audit purposes, or pursuant to a Federal court order. The Committee is aware that releases signed to permit disclosure of such records may be less than truly voluntary given the pressures inherent in pre-employment situations.

Prohibition of Discrimination against Substance Abusers

The final substantive provision contained in the new subchapter on patient rights would be included as a new section 4133, to incorporate into title 38 the proscription against discrimination against alcohol or drug abusers in the admission of otherwise eligible veterans to VA health care facilities. This prohibition is now contained in section 321 of the 1970 comprehensive alcohol act and section 407 of the 1972 drug act (as amended by Public Law 94-237).

Many hospitals—including VA hospitals—are reluctant to admit alcohol or drug abusers for hospitalization. In 1969, the American Hospital Association described the situation in these words:

The reluctance of hospitals to admit patients with alcohol and other drug problems is often based on a misconception that, because these patients are uncontrollable and disruptive, special facilities and staff are required for their care. The truth is they are not. Professional knowledge is required, not special units; the successful management of such patients in regular units is well documented. . . .

Failure to admit alcoholics and patients with other drug problems denies them the benefits that would be available in cases of poisoning due to other causes; similarly, it denies hospital personnel and house staff the opportunity for education in the management of such cases.

The new section 4133 to be added to title 38 by the Committee bill would prohibit discrimination against alcohol and drug abusing eligible veterans in admission to, or treatment at, VA health care facilities. The Administrator would be required to prescribe regulations for the implementation of this nondiscrimination policy. The provision is

not intended to *require* the admission or treatment of such veterans, nor to require that they be given *preferential* treatment. The provision is also not designed to preclude agreements among VA hospitals for the division of responsibility for treatment of alcohol or drug abuse.

The provision is intended to incorporate into title 38 a statutory declaration that alcohol and drug abusers are entitled to the same right to medical treatment as are other eligible veterans.

Coordination with other Government programs

The Committee bill retains virtually intact the provisions of the existing comprehensive drug abuse and alcoholism laws which require the VA, in prescribing regulations governing drug abuse and alcoholism medical records and in establishing drug abuse and alcoholism nondiscrimination policy regulations with respect to DM&S programs, to make applicable, to the maximum extent feasible consistent with the provisions of title 38, the regulations prescribed by the Secretary of Health, Education, and Welfare pursuant to those laws and to consult with the Secretary with respect thereto and to seek the maximum possible coordination of regulations and policies. However, if the Administrator finds that application of the HEW regulations is not consistent with title 38 provisions, he is required by the Committee bill, as under existing law, to publish in the Federal Register and submit to the Congressional Committees a report explaining any such inconsistency and the results of the consultations with the Secretary regarding the regulations.

Thus, the Administrator and the Chief Medical Director, as under existing law, retain the ultimate and total authority, as they do under title 38, to prescribe regulations and establish policies to carry out their title 38 responsibilities with respect to the VA hospital and medical program.

The Committee bill adds to this statutory scheme to promote uniformity of policies and regulations between VA and HEW programs, the proscription of human experimentation, informed consent procedures, forms, and policies consistent with those adopted by HEW based on the recommendations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Again, the Administrator and the Chief Medical Director would retain their present policymaking and administrative control over the program.

Coordination With Other Programs and Reports

There are a number of other provisions in the Committee bill dealing with coordination between VA programs and programs of other Federal agencies or community health care programs.

Sharing of Emergency Room Facilities

One program which has been of significant value in furthering this cooperation has been the sharing of specialized medical resources. This decade-old program permits VA hospitals to share specialized medical resources (other than regular hospital beds) which, because of their cost, limited availability, or unusual nature, are either unique in

the medical community or are subject to maximum utilization only through mutual use.

Under this program a steady growth in the number of sharing agreements has occurred. Last year, 82 VA hospitals participated in a total of 152 sharing arrangements, representing a total contractual commitment of \$10,815,895 in medical services and resources. Under these mutually reimbursable arrangements, services furnished by the VA represented \$4,574,363 in cost, and services furnished to the VA represented \$6,241,532. Most of these sharing agreements were with other Federal facilities, particularly with those of the uniformed services, although there is a growing movement toward more of these agreements with affiliated university medical centers and community hospitals.

Section 120 of the Committee bill would specify that the VA may obtain the use of emergency room facilities through sharing agreements for the treatment of veterans in need of care for their service-connected disabilities, or for veterans in a post-VA-hospital-care status or who have a service-connected disability rated at 50 percent or more, but only in medical emergencies which pose a serious threat to life or health where the VA determines the emergency treatment capacity is necessary for the care of such veterans but that it would be too costly and duplicative to provide the capacity in the VA facility.

Social Security Administration Reimbursement for Medicare Eligibles Treated Under Sharing Agreements

Second, section 120 would authorize reimbursement—on terms agreed to by the VA and HEW—to the VA by the Social Security Administration when a Medicare-eligible patient is treated in a VA hospital under a sharing arrangement with a community facility as that facility's patient.

Prior to 1974, VA hospitals routinely received non-VA end stage renal disease (ESRD) patients (primarily for renal transplantation and maintenance dialysis) from non-VA sharing hospitals. This relatively expensive treatment was provided by the VA hospitals, subject to the proviso contained in section 5053 of title 38 that the full cost of the treatment would be reimbursed by the sharing hospital. The sharing facilities were reimbursed for their liability to the VA for these services primarily from Medicare. The proportion of the cost of such services not reimbursable under Medicare, as well as the non-Medicare-covered expenses, came from a number of sources, including the patients, State funding sources, or the bad debts provisions of the Medicare law.

In October, 1972, the enactment of Public Law 92-603 expanded Medicare coverage to certain types of conditions, including ESRD, without limitation according to age. This increased the number of ESRD patients in the private-sector facilities, including those hospitals with which the VA had agreements to provide treatment to ESRD patients in the VA facility.

In 1973, the Social Security Administration (SSA) discontinued Medicare payments to the sharing non-VA hospitals, based on its determination that the ESRD services being paid for by Medicare were not being provided, in the strict statutory sense, by the sharing hospital as required by Medicare law, but, in fact, were being provided by another facility altogether—the VA. Under section 1814(c) of the

Social Security Act, unless a Federal facility is determined to be a "community provider"—which VA hospitals were not—Medicare cannot pay for non-emergency treatment given at such a facility. Accordingly, it was determined that direct Medicare reimbursement of VA facilities was statutorily precluded as well. The sharing hospitals thus lost a regular Medicare income of thousands of dollars. Absent this income, most hospitals refused to pay the VA hospitals for the ESRD treatment rendered to their sharing patients despite the existence of a binding contract requiring such payment. This meant that the full-cost reimbursement requirement of section 5053 of title 38 was not being met, and the sharing agreements were thus placed in jeopardy.

Since early 1974, the VA has been working with SSA to remedy this problem. To preserve the sharing arrangements, collection efforts against the sharing hospitals have not been pressed, and VA hospitals have continued to admit ESRD patients.

In a series of meetings commencing in 1974 (and precipitated by requests from the Committee and the Senate Committee on Finance), VA and SSA officials discussed three possible alternatives to resolve the impasse. One was for SSA to declare the VA hospitals "community providers" for purposes of the services covered by the sharing contract. A second was to consider the shared VA facilities as merely an "extension" of the sharing hospitals. A third was an "under arrangements" concept, wherein the VA would be considered as providing certain specified services under a contract with the provider hospital.

The latter two alternatives were subsequently determined not to be feasible. The "extension" concept would require that controls over the shared activities or facilities be exclusively in the sharing facility, while the "under arrangements" approach would not cover those items or services deemed to be inpatient in nature.

Soon after a May, 1974, meeting attended by staff representatives of the Committee, the Senate Committee on Finance, the VA, and SSA, SSA agreed, for ESRD purposes only, to consider designated VA hospitals as "community providers". As such, each of the VA hospitals so designated would be a Medicare provider in its own right.

In September 1974, the Administrator of Veterans' Affairs and the Secretary of Health, Education, and Welfare signed a memorandum of understanding which designated 20 VA hospitals named in an attachment thereto as "community providers" for purposes of Medicare ESRD reimbursement. The full text of that memorandum was as follows:

MEMORANDUM OF UNDERSTANDING

The Administrator of Veterans' Affairs and Secretary of Health, Education, and Welfare—

Recognizing that the Congress enacted Section 2991 of the Social Security Amendments of 1972, Public Law 92-603 (amending section 226 of the Social Security Act, 42 U.S.C. 426) in order to establish a comprehensive system of benefits under the Medicare program for individuals with End-Stage Renal Disease;

Recognizing that the Congress was concerned that this program be administered to assure that facilities for the treatment of End-Stage Renal Disease be utilized to their maximum effectiveness with a minimum of duplication; and

Recognizing further that certain hospitals of the Veterans' Administration are significantly involved in contributing to the treatment of End-Stage Renal Disease within the United States;

Enter into this Memorandum of Understanding in order to coordinate the programs respectively administered by them with respect to items or services involving the treatment of individuals with End-Stage Renal Disease. Specifically, it is agreed that:

1. This Memorandum of Understanding applies only to items or services, otherwise covered by the Medicare program, for the treatment of End-Stage Renal Disease furnished by Veterans Administration hospitals on and after July 1, 1973, under sharing agreements entered into by such hospitals pursuant to 38 U.S.C. 5053 with hospitals participating in the Medicare program as providers of services thereunder (such Veterans Administration hospitals being listed in Schedule A attached hereto as a part of this Memorandum of Understanding);

2. Because of the scarcity of facilities for the treatment of End-Stage Renal Disease and the role played with respect to such treatment by the Veterans Administration hospitals listed in Schedule A pursuant to sharing agreements under 38 U.S.C. 5053, such hospitals are considered, for purposes of this Memorandum of Understanding, community institutions or agencies for purposes of Sections 1814(c) and 1835 (d) of the Social Security Act, 42 U.S.C. 1395f(c) and 1395n (d);

3. Except to the extent permitted by Section 1866(a)(2) of the Social Security Act and regulations issued thereunder, no individual or any other person shall be charged for items or services with respect to which a provider of services is precluded by reason of Section 1866(a)(1) of such Act from charging such individual or such other person, and any moneys collected from such individual or such other person shall be returned or made subject to such other dispositions as may be specified in regulations. This provision accordingly does not preclude any of the Veterans Administration hospitals listed in Schedule A from seeking and receiving reimbursement from another hospital, in accordance with the terms of a sharing agreement entered into pursuant to 38 U.S.C. 5053, for items or services not covered by Medicare;

4. This Memorandum of Understanding may be rescinded with respect to one or more hospitals listed in Schedule A by either the Secretary of Health, Education, and Welfare or the Administrator of Veterans Affairs in accordance with the provisions of section 1866(b)(1) and (2) of the Social Security Act and regulations thereunder. In the event of such

rescission, the obligations of the Secretary of Health, Education, and Welfare to make payment for the furnishing of items and services described in paragraph 1 hereof shall be abrogated to the extent specified in section 1866(b)(3) of such Act and regulations thereunder.

DONALD E. JOHNSON,
Administrator of Veterans Affairs,
 CASPAR W. WEINBERGER,

Secretary of Health, Education, and Welfare.
 SEPTEMBER 4, 1974.

SCHEDULE A—ACCOMPANYING MEMORANDUM OF
 UNDERSTANDING

Between the Administrator of Veterans' Affairs and the Secretary of Health, Education, and Welfare, regarding coordination of the programs administered by them with respect to items or services involving the treatment of individuals with End-Stage Renal Disease.

The Veterans Administration hospitals in the following locations, which have entered into sharing agreements with hospitals participating in the Medicare program, are included in the Memorandum of Understanding:

1. Albuquerque, New Mexico
2. Ann Arbor, Michigan
3. Birmingham, Alabama
4. Denver, Colorado
5. Durham, North Carolina
6. Hines, Illinois
7. Indianapolis, Indiana
8. Iowa City, Iowa
9. Lexington, Kentucky
10. Little Rock, Arkansas
11. Madison, Wisconsin
12. Nashville, Tennessee
13. Oklahoma City, Oklahoma
14. Richmond, Virginia
15. St. Louis, Missouri
16. Salem, Virginia
17. Salt Lake City, Utah
18. San Juan, Puerto Rico
19. Seattle, Washington
20. Tucson, Arizona

Two new problems have developed, however, since the implementation of the memorandum of understanding.

First, during the negotiations leading to the 1974 memorandum of understanding, the VA did not anticipate that its participation in Medicare ESRD reimbursement would be conditioned on continued compliance with two separate sets of detailed Medicare regulations, both subject periodically to revision and drafted for application to the broad public sector, without specific consideration of the particular needs of the VA hospital system. Second, designation of ESRD provider status for certain VA hospitals has raised the possibility of bill-

ing, reimbursement, and other administrative problems, and has, in some instances, threatened substantial economic dislocation for the facilities which are sharing partners of those VA hospitals. A brief discussion of these two problems follows.

Compliance with Medicare regulations.—To be eligible for Medicare reimbursement, hospitals must meet certain criteria pertaining to utilization review which are contained in Medicare regulations. At the time the memorandum of understanding was signed in 1974, SSA considered accreditation by the Joint Commission on Accreditation of Hospitals and a functioning review procedure to be *prima facie* evidence of compliance with the regulations. Because all of the participating VA hospitals were JCAH-accredited, and the Chief Medical Director had instituted a VA quality control program throughout the VA hospital system which included a utilization review procedure, satisfaction of these criteria seemed to be readily accomplished. Recently, however, HEW, pursuant to its statutory authority under Medicare law, has sought to impose new regulatory standards more stringent than those of the JCAH as a condition of basic Medicare provider certification. Thus, participating VA facilities, in order to achieve "provider" status, would have to meet new, higher standards on any hospital-related matters within the purview of HEW's regulatory authority.

Very recently, in addition to the aforementioned regulations defining the obligations of hospitals eligible for reimbursement as general Medicare providers, HEW promulgated a detailed new set of regulations (*Fed. Reg.*, daily ed., June 3, 1976, pp. 22509–22522), imposing, as an additional requirement for reimbursement under Medicare, special standards for the provision of ESRD care. These regulations include controls over expansion of ESRD facilities, minimum use standards for such facilities, and treatment review by local ESRD providers and HEW. Many of the requirements seem particularly onerous insofar as the VA is concerned, and were not drafted with the particular needs of Federal providers in mind. Specifically, the VA has expressed concern that the regulations require a Federal agency to comply with a maze of State and local health and safety requirements and would further require the agency to comply with detailed ESRD treatment standards which do not take into account the specialized nature of the VA hospital system.

Although negotiations between SSA and VA officials since 1974 have partially resolved many of the problems inherent in the application of both sets of generalized Medicare regulations to the VA hospital system, serious problems remain and could jeopardize the VA's participation in sharing programs involving Medicare ESRD patients.

ESRD reimbursement.—In accordance with Medicare provisions, each participating VA hospital is responsible for the submission of billings, in its own name, for the treatment of ESRD Medicare patients. The sharing hospital cannot include such costs as part of its own billings. However, VA hospitals do not operate under a patient billing system, and indeed lack legal authority to bill sharing patients. Accordingly, the VA and SSA have been attempting to develop a billing system which would be operated by the sharing hospital, with some assistance from VA personnel.

However, the sharing hospitals have expressed concern that, under applicable Medicare law, the administrative billing costs which they incur under this system might not be fully reimbursed by Medicare. Furthermore, although the VA and SSA anticipate that the sharing hospital's normal Medicare billing procedures (as to bills submitted to SSA as well as the Medicare-covered patient) would yield the full cost reimbursement required by title 38 as a condition of a sharing arrangement, there is concern on the part of the sharing hospitals that full reimbursement will not in fact be received, and that the VA will seek to recover the remainder from them.

These uncertainties and concerns over billing and reimbursement arrangements have seriously hampered full implementation of the 1974 memorandum of understanding.

It is clear to the Committee that the informal 1974 agreement cannot be regarded as the final solution to the difficult problems associated with the VA's status as a Medicare provider, and that a permanent statutory solution is now necessary so that the VA and HEW can design standards and procedures geared to the particular needs of VA hospitals.

Committee bill provision.—To provide that solution, the Committee bill adds at the end of section 5053 of title 38 a new subsection (d). The new subsection provides that when a VA facility furnishes hospital care or medical services, pursuant to a specialized medical resources sharing agreement under section 5053, to an individual whose medical expenses would otherwise be covered under Medicare (which may in rare circumstances include a Medicare-eligible veteran electing to receive treatment in the VA hospital as a "sharing" patient rather than directly), the VA facility (or, if the sharing agreement so provides, the non-VA facility which is a party to the agreement) will be reimbursed at rates, and according to procedures, agreed upon by the Secretary of HEW and the Administrator of Veterans' Affairs.

In the Committee's view, this new subsection would permit the implementation of a "reimbursement model" that would satisfy the concerns of SSA the VA, and the affiliated sharing hospitals as well as resolve the problems which have arisen in the wake of the 1974 memorandum of understanding.

First of all, subsection (d) would give the VA and SSA discretion to work out satisfactory methods for assuring that all the governing regulations, including those concerning quality and utilization review procedures, can work effectively to achieve their purposes and are suited to the particular needs and status of the VA health care system.

Second, new subsection (d) would permit resolution of the difficult billing and reimbursement problems which have arisen between the VA and affiliated sharing hospitals. The VA and SSA would be authorized to develop a billing system whereby a major portion of the billing function for patients treated in VA facilities would be performed under contract by the affiliated hospital, with some assistance from VA personnel. Billings for the coinsurance, deductible, and non-covered items would be done by the sharing hospital, through its own collection system. For those debts uncollectible by the sharing hospital, SSA has advised that the VA could seek reimbursement under the Medicare bad debts provision. In the last analysis, however, if full recovery is not realized by this process, in accordance with section

5053 of title 38, the VA would still be required to look to the sharing hospital to make up any deficit which might remain. The Administrative costs entailed by billing and related activities on the part of the sharing hospital and of the VA would be reimbursed by HEW. Under this model the SSA payments would be made directly to the VA hospital which provided the service.

VA ESRD costs would not be allowed by Medicare to the extent that they exceed SSA's determination of the "reasonable cost" of the item, while section 5053 of title 38 requires that the VA obtain "full cost" reimbursement for sharing services. The Committee believes that these concepts are compatible.

This amendment is designed to give the VA and SSA discretion to work out satisfactory methods for determining reasonable costs and assuring quality and utilization review procedures, while tailoring the final terms and conditions to the particular needs and status of the VA hospital system.

What must be avoided is a situation which, because agencies of the Federal Government cannot agree between themselves, results in an unwise and costly duplication of expensive facilities which exist and have unused capacity in a particular area. Such proliferation is highly inflationary and poses one of the major dilemmas in health care today. It is this unfortunate situation that the amendment is designed to avoid.

Although the greatest need for this provision relates to the ESRD program at present, enactment of this amendment will also facilitate the extension of such VA-Medicare sharing arrangements to other types of conditions, such as stroke care or open heart surgery in the future if the VA and HEW are able to work out agreements pursuant to this legislation for those purposes.

This new provision has been fully coordinated with the Senate Finance Committee, and has been endorsed by the Administration in the VA's March 2, 1976, report on S. 2908.

Coordination With Other HEW Health Activities

Third, section 120 would require the VA to coordinate the comparable aspects of the VA's quality assurance mechanism, called "Health Service Review Organization" (HSRO), with Medicare's and Medicaid's "Professional Standards Review Organization" (PSRO) at the national and regional levels.

Fourth, section 120 would require the Chief Medical Director to prepare an annual report to Congress on the results of his activities in coordinating VA activities with other programs, such as PSRO, and in acting in an advisory capacity pursuant to other Federal laws, or administratively created coordinating or advisory bodies in such areas as cancer, heart disease, arthritis, emergency medical services, alcohol abuse, aging research, health services research and statistics, health planning and resource development, and so forth.

Assistance to Health Manpower Training Institutions

Section 121 of the Committee bill would extend the current exception to the 3-year limitation on leasing VA lands and buildings in the case of leases to new medical schools supported under subchapter I of chapter 82, to those medical schools and other health training institutions receiving grant support under subchapters II and III of that

chapter. This provision will permit the VA to make long-term leases to existing medical and other health care personnel training schools with which VA hospitals are affiliated and which are receiving assistance under the authorities of chapter 82.

This provision, by permitting the construction of educational facilities at VA hospital sites, would be of significant value to those existing training institutions entering into a new affiliation with a VA hospital at some distance from their location. The existence of a facility which faculty members and medical and other health professional students can use for training purposes at the hospital site will enhance the health services programs of the hospitals as well, without creating a demand for space needed for patient care in the hospital itself.

Section 121 would also require the VA to report to Congress annually on programs authorized by chapter 82, including an evaluation of their effectiveness in achieving their purposes, an appraisal of the contributions of such programs in improving the quantity and quality of physicians and other health care personnel furnishing hospital care and medical services to veterans in VA facilities; a list of the approved but unfunded projects and the funds needed to support such projects; and recommendations for the improvement of and more effective administration of the programs, including any necessary legislation.

Community Nursing Home Care

Section 108 of the Committee bill would remove certain statutory restrictions on the placement of veterans in community nursing homes at VA expense.

Reimbursement rate for nursing homes

Section 108 would allow greater flexibility in the rate of VA reimbursement which is permitted for skilled community nursing home care. The Committee is concerned that certain VA hospitals may be unable to find community nursing home placements for veterans who no longer need the level of care provided in a hospital, due to the present VA statutory limitation on the VA's authority to reimburse the homes at a level adequate to cover costs, thus raising the possibility of veterans remaining hospitalized beyond their appropriate discharge dates, at a considerable additional cost to the Federal government and contrary to the dictates of sound medical practice.

Under current law (section 620(a)(ii)), the maximum reimbursement rate for nursing homes is limited to 40 percent of the cost of general care in the VA hospital in the pertinent geographical area. The Committee bill would increase this maximum to 45 percent of the cost of care in the comparable VA hospital, and would permit the rate to go as high as 50 percent of that cost where that higher level of reimbursement is determined essential to provide adequate care.

Placement in intermediate care facilities

The Committee is aware of the steadily growing cost of the community nursing home care program, and believes that the present statutory provision (in section 620(a)) limiting the VA to contracts with skilled nursing home care facilities has resulted in the placement of a substantial number of veterans in facilities offering a more highly specialized level of care than is needed. The Committee bill, therefore,

would permit the placement of a veteran in an intermediate care facility at VA expense where the veteran is not in need of the level of care provided by a skilled nursing home.

The Committee bill provides that the reimbursement cost of such intermediate care would be determined by the VA, and would be commensurately less than that provided for skilled nursing home care in the community. The VA has advised the Committee that 30 percent of the veterans now placed in community nursing homes require only intermediate nursing care. Thus, enactment of the provision authorizing placement in an intermediate care facility would result in cost savings estimated at \$22.6 million over a six year period.

Alternatively, cost savings entailed by the transfer of VA patients to intermediate care facilities would enable the already tightly budgeted funds for providing community nursing home care to be stretched to provide benefits to a larger number of veterans in need of extended care.

Discretionary direct admission of veterans with non-service-connected disabilities

Section 108 would also amend section 620 to authorize discretionary direct admission of veterans with non-service-connected disabilities to community nursing home care facilities. Under existing law (section 620(d)), such direct admission is authorized only for veterans requiring nursing home care for service-connected disability. The Committee bill would permit the VA to authorize direct admission of other veterans in accordance with the special priorities described in new section 612(i) (as added by section 104(a)(9) of the Committee bill) and on a discretionary basis subject to the availability of funds.

Caring for the Growing Number of Elderly Veterans

The average age of American veterans is approaching 50 years. Approximately 14 million veterans are now between the ages of 50 and 60. As this enormous population of middle-aged veterans approaches old age during the next decade, critically important policy decisions will confront the VA, and the VA's health care capacity will have to be revised and expanded in major new directions. An important objective of the Committee bill is to encourage initial short-range and long-range planning in the VA to adapt the current health care program to accommodate the growing number of elderly veterans in the United States and the increasing average age of those who need care in VA health care facilities.

For more than 10 years, the VA's proportional commitment of resources to health care programs for elderly veterans has steadily grown. The VA has operated its own nursing home care beds since 1964, and during fiscal year 1975 spent \$105 million to provide care to more than 10,000 veterans in 88 hospital and nursing home facilities. In addition to its own nursing home care beds, the VA has an active community nursing home placement program which, in fiscal year 1975, provided care to almost 22,000 elderly veterans in 3,300 community facilities at a total cost to the VA of \$47 million. Other VA programs which benefit primarily elderly veterans are the grant-in-aid program to State veterans nursing care homes (costing \$9,400,000 in VA funds in fiscal year 1975); the Hospital-Based Home Care Program; and research

and patient-care activities performed in the recently established Geriatric Research, Education, and Clinical Centers.

The Committee is nevertheless concerned that these programs at their present levels may not be sufficient, in and of themselves, to meet the potential health care needs—especially the extended care needs—of the extraordinarily large number of elderly veterans who will be seeking health care benefits a decade from now. In fiscal year 1975, according to figures supplied to the Committee by the VA, expenditures on health care programs benefiting primarily elderly veterans amounted to approximately \$225 million, or 6 percent of the total VA health care expenditure of \$3,771 billion that year—despite the fact that 1 out of every 4 veterans seeking care in a VA facility was over 65 years of age.

Section 122 of the Committee bill would require the Chief Medical Director to prepare a study of short-range and long-range steps necessary to adapt the VA's health care program to the changing demography of the nation's veterans population. As part of the study, the Chief Medical Director would be required to submit specific plans for adjusting the number of hospital and extended care beds, developing alternatives to institutional care, employing and training personnel with special geriatric care skills, and making the necessary architectural, structural, and environmental modifications to VA health care facilities to permit access for the elderly.

Preparing the VA health care system for the new and different demands that an aging veterans population will make on existing programs and facilities will be, in the Committee's view, one of the most profound challenges to face the VA in the next 10 years. The study mandated by this section of the Committee bill would stimulate the preliminary thought and planning that must commence immediately if the Department of Medicine and Surgery is to deal adequately with the problem.

COST ESTIMATE

In accordance with section 252(a) of the Legislative Reorganization Act of 1970 (Pub. Law 91-510, 91st Congress), the Committee, based on information supplied by the Veterans' Administration and the Congressional Budget Office, estimates that the cost resulting from the enactment of S. 2908, as reported, would be \$36,480,000 in fiscal year 1977; \$39,000,000 in fiscal year 1978; \$38,170,000 in fiscal year 1979; \$41,800,000 in fiscal year 1980; and \$45,570,000 in fiscal year

1981. A detailed breakdown of these costs over the 5-year period follows:

[Dollars in millions]

Section	1977	1978	1979	1980	1981
101—Travel allowances.....	-10.18	-10.18	-10.18	-10.18	-10.18
102(2).....					
Family counseling.....	13.04	14.43	16.00	17.70	19.53
Family mental health services.....					
104(a)(1)—Structural improvements, NSC.....	.25	.75	.88	.75	.63
104(a)(2 and 3)—Dental services.....	4.16	4.61	5.10	5.65	6.25
104(a)(7)—80 to 50 percent.....					
104(a)(8)—Structural improvements, SC.....	.39	1.20	1.01	.81	.61
105—.....					
Readjustment counseling.....	7.94	5.28	1.14	1.21	1.27
Outpatient mental health.....	2.41	2.53	2.66	2.80	2.94
106—CHAMPVA.....	.06	.06	.06	.07	.07
108—ICF's.....	-5.26	-5.91	-6.57	-7.25	-7.88
110—Prevention program.....	6.19	8.89	10.67	12.40	15.57
113(a)—Pay adjustment.....	1.00	1.00	1.00	1.00	1.00
114(b)—Optometrists and podiatrists.....	.69	1.66	2.73	3.90	5.18
116—Special pay.....	4.28	8.43	7.38	6.60	4.13
119—Nursing home beds increase ¹					
Title II—Drug and alcohol treatment.....	11.51	6.25	6.29	6.34	6.45
Total.....	36.48	39.00	38.17	41.80	45.57

¹ In all respects save one, the Committee has adopted the cost estimate of the Congressional Budget Office as its own estimate. The exception is section 118 of the bill as reported, requiring an increase in the statutory minimum number of VA nursing home care beds from 8,000 to 10,000 by fiscal year 1980. The VA has advised the committee that current planning anticipates that the operating bed level for nursing home care will reach 10,000 by fiscal year 1980. Accordingly, the Committee believes that the cost of the increase in nursing home care bed capacity is not a cost reasonably attributable to the enactment of S. 2908.

SECTION-BY-SECTION ANALYSIS OF S. 2908, AS REPORTED

Section 1

Provides that this Act may be cited as the "Veterans Omnibus Health Care Act of 1976".

TITLE I—GENERAL VETERANS HEALTH CARE AND DEPARTMENT OF MEDICINE AND SURGERY AMENDMENTS

Section 101

Amends section 111 of title 38, United States Code, relating to reimbursement of veterans for the cost of travel expenses incurred for trips to or from a Veterans' Administration facility.

Clause (1) of section 101 makes a clarifying amendment in subsection (a) of section 111 so that new subsection (e) (added by clause 2) would be controlling with respect to reimbursement for the cost of beneficiary travel expenses.

Clause (2) of section 101 adds a new subsection (e) to section 111, as follows:

New subsection (e): Paragraph (1) directs the Administrator of Veterans' Affairs, after consultation with the heads of other relevant Federal Departments and agencies, to establish (on at least an annual basis)) rates of reimbursement based on an analysis of the costs of alternative modes or travel.

Paragraph (2) establishes three fundamental rules to govern the reimbursement of veterans for the cost of travel expenses. (1) Veterans not receiving care for or in connection with a service-connected disability, as a precondition for receiving any reimbursement at all under this section, must, on the basis of an annual declaration and certification, be determined to be unable to defray the expenses of such travel. (2) Veterans eligible for reimbursement are reimbursed for the cost of travel by public transportation, except under three circumstances in which reimbursement for the cost of travel by privately owned vehicle is authorized: (a) When public transportation is not reasonably accessible, (b) when travel by public transportation is deemed medically inadvisable, or (c) when the cost of travel by privately owned vehicle is actually less than the cost of travel by public transportation. (3) Under no circumstances are veterans to be reimbursed for any amount in excess of the actual expenses incurred, as certified in writing by the person claiming reimbursement.

Paragraph (3) requires the Administrator to review and analyze several objective factors in determining rates of reimbursement under this section. Among the factors specified in paragraph (3) are (a) vehicle operation costs (including depreciation, fuel, maintenance, operation, and taxes), (b) the availability and relative convenience of public transportation, and (c) the travel expense reimbursement rates for Federal employees under sections 5702 and 5704 of title 5, United States Code.

Paragraph (4) requires that, before determining the rates of reimbursement specified in the new subsection (e), the Administrator publish in the Federal Register and report to Congress on the proposed rates, with a justification and an explanation of any differences between the rates proposed and the existing rates for Federal employees in effect under sections 5702 and 5704 of title 5.

Enactment of section 101 of the Committee bill will result in an annual cost saving of \$10.18 million.

Section 102

Amends section 601 of title 38, United States Code, to clarify the definitions of several terms used in chapter 17 of title 38, and to add several new definitions. The definitions to be amended or added by clauses (1) and (4) of this section are virtually identical to provisions which were passed in the Senate in S. 2108 in the 92d Congress and in S. 284 in the 93d Congress.

Clause (1) of section 102 makes conforming changes in the definition of "hospital care" in paragraph (5) of section 601 to accord with the amendments made by clauses (2) and (4) of this section (see below).

Clause (2) of section 102 revises the definition of "medical services" contained in paragraph (6) of section 601. Under the new definition, "medical services" consist of two components, in addition to medical examination, treatment, and rehabilitative services: (1) Professional

services as described in a new clause (A) in paragraph (6), including optometry, podiatry, surgery, dentistry, dental and other appliances, prosthetics, and others, and transportation and incidental expenses associated therewith (as determined under section 111 (as amended by section 101 of the Committee bill)). (2) Services for family members of veterans, as described in a new clause (B) in paragraph (6), as follows: (i) Consultation, professional counseling, and training for family members of veterans being treated for service-connected non-service-connected disabilities, (ii) Mental health services for family members of veterans being treated for service-connected disabilities or for readjustment problems diagnosed pursuant to section 612A (as added by section 105 of the Committee bill) of title 38. (iii) In the discretion of the Administrator, mental health services for family members of veterans being treated for non-service-connected disabilities if such treatment commenced while the veteran was hospitalized. No service may be provided to a family member as part of "medical services" under paragraph (6) unless the service is determined to be essential to the effective treatment and rehabilitation of the veteran and unless the person to whom the service is provided is a member of the veteran's immediate family, the veteran's legal guardian, or any individual in whose household the veteran certifies an intention to live.

The family counseling provisions contained in clause (2) of section 102 will cost \$13.04 million fiscal year 1977.

Clause (3) of section 102 amends the definition of "domiciliary care" in paragraph (7) of section 601 to make reference to "medical services" (as defined in paragraph (6) of such section).

Clause (4) of section 102 amends section 601 by adding a new paragraph (8) defining "rehabilitative services". Under paragraph (6) (as amended by clause (2) of this section) of section 601, rehabilitative services are included under "medical services" and, therefore, are also part of "hospital care" under paragraph (5) (as amended by clause (1) of this section) of section 601.

New paragraph (8): Defines "rehabilitative services" as professional, counseling, and guidance services and treatment programs necessary to restore the physical, mental, and psychological functioning of an ill or disabled person. Rehabilitative services would include vocational guidance and rehabilitation services other than those provided as part of vocational rehabilitation under chapter 31 of title 38.

Section 103

Adds a new section 603 to subchapter I of chapter 17 of title 38, United States Code, to create a presumption of service-connection for disabilities suffered by former prisoners of war, under certain circumstances.

Subsection (a) of section 103 adds a new section 603 at the end of subchapter I of chapter 17, as follows:

New section 603: Creates a presumption of service-connection for any disability which, on the basis of sound medical judgment, could have been incurred during or aggravated by internment as a prisoner of war, if the veteran was interned for more than 6 months and the Administrator does not find, on the basis of clear and convincing evi-

dence, that the disability is not attributable to or aggravated by the period of internment.

Subsection (b) of section 103 amends the table of sections at the beginning of chapter 17 to reflect the addition of the new section 603 made by subsection (a) of this section of the Committee bill.

Section 104

Amends section 612 of title 38 (relating to eligibility for outpatient medical treatment) to clarify the circumstances under which veterans with service-connected or non-service-connected disabilities qualify for outpatient medical services.

Clause (1) of subsection (a) of section 104 amends subsection (a) of section 612 by authorizing, as part of the outpatient treatment program for a veteran's service-connected disability, such home health services as the Administrator finds to be necessary or appropriate for the effective and economical treatment of the disability. These home health services would include improvements and structural alterations to the veterans home, but (1) only as necessary to assure the continuation of treatment for such disability or to provide access to the home or to essential lavatory and sanitary facilities, and (2) only to the extent that the cost of the improvement or alteration does not exceed the cost of the average period of hospitalization in VA facilities, as determined annually by the Administrator; and, if so, the VA may reimburse up to that amount.

Enactment of this provision will cost \$250,000 in fiscal year 1977.

Clause (2) of subsection (a) of section 104 amends subsection (b)(4) of section 612 (which specifies the dental conditions or disabilities for which outpatient dental services and treatment may be provided) to authorize the provision of outpatient dental services and treatment (but not including any routine dental care) to any veteran with a dental condition or disability which is associated with or aggravating a medical or dental disability for which the veteran is then receiving treatment at a VA facility. At present, the authority to provide outpatient services and treatment for a non-service-connected dental condition or disability is limited to the treatment of those conditions or disabilities associated with a service-connected disease or injury. This amendment broadens, to a very limited degree, the authority to provide outpatient dental services and treatment, so that a veteran with a dental condition or disability associated with any disease or injury—regardless of service-connection—can receive dental services and treatment, on an outpatient basis, if the dental condition or disability is associated with or aggravating the disease or injury for which the veteran is then receiving outpatient treatment under section 612(f).

Clause (3) of subsection (a) of section 104 further amends subsection (b) of section 612 by adding a new clause (5) to define a second circumstance under which a veteran may receive outpatient dental services and treatment for a non-service-connected dental condition or disability, and redesignating the existing clause (5) as clause (6).

New clause (5): Authorizes the provision of outpatient dental services and treatment to a veteran for a non-service-connected condition or disability if treatment for the dental problem began while the

veteran was receiving hospital care under chapter 17 of title 38, and treatment of the dental problem on an outpatient basis is reasonably necessary to complete the treatment begun during hospitalization.

Enactment of the provisions relating to outpatient dental services contained in clauses (2) and (3) of this section of the Committee bill will cost \$4.16 million in fiscal year 1977.

Clause (4) of subsection (a) of section 104 amends subsection (f) of section 612 (specifying circumstances under which medical services may be provided on an outpatient basis for a non-service-connected disability) by providing that such services may be furnished only within the limits of VA facilities, as the latter term is defined in paragraph (4) of section 601. The amendment is designed to overrule an interpretation of the VA holding that under present law a veteran with a non-service-connected disability can receive fee-basis outpatient treatment under section 612(f) without limitation because of the absence of the words "within the limits of Veterans' Administration facilities" from section 612(f), whereas a veteran can receive outpatient treatment for a service-connected disability on a fee basis only within certain limits because of the words "within the limits of Veterans' Administration facilities" in section 612(a).

Under section 601(4) (as amended by section 302(b)(2) of the bill), a VA facility includes a private facility for which the Administrator contracts in order to provide medical services for the treatment of a service-connected disability. A veteran seeking treatment for a service-connected disability can, therefore, utilize the services of a private facility on a fee basis, since such facility is defined as a VA facility under section 601(4)(C)(i), while, under the amendment to section 612(f), a veteran seeking treatment for a non-service-connected disability could not, since a private facility is defined as a VA facility only when utilized for the treatment of a service-connected disability. The effect of the amendment would be to make clear that the VA does not have authority to authorize fee-basis outpatient treatment for veterans with non-service-connected disabilities, except (by virtue of the amendment in section 302(b)(2) of the Committee bill) with respect to veterans with service-connected disabilities rated at 50 percent or more or as part of post-hospital care.

Clause (5) of subsection (a) of section 104 amends section 612(f) (1) to limit the circumstances under which outpatient or ambulatory care may be provided to a veteran to obviate the need of hospitalization for a non-service-connected disability or illness. The amendment provides that such care may be provided only to the extent that VA outpatient or ambulatory facilities are available. Present section 612(f) establishes four categories of veterans eligible for outpatient or ambulatory medical services: (1) Veterans eligible for hospital care and in need of preparation for hospital admission; (2) veterans eligible for hospital care for whom such services are reasonably necessary to obviate hospital admission; (3) veterans who have received hospital care and for whom such services are reasonably necessary to complete treatment incident to hospitalization; and (4) veterans with service-connected disabilities rated at 80 percent or more. The effect of this amendment would be to provide outpatient or ambulatory services for veterans in the "obviate" category only to the extent that outpatient or ambulatory care capacity is still available after veterans in

the other three categories have received such services. Last priority in the provision of such services for non-service-connected disabilities would thus be given to those veterans for whom the services are provided under the "obviate" language in section 612(f) (1) (A).

Clause (6) of subsection (a) of section 104 limits the duration of outpatient or ambulatory services that may be provided to veterans receiving such services as post-hospital care under section 612(f) (1) (B). For veterans who have received hospital care and for whom post-hospital outpatient or ambulatory care is reasonably necessary to complete treatment incident to such hospitalization, such post-hospital outpatient care would be limited to a period not longer than 12 months after discharge from the hospital, subject to specified exceptions, as follows: If the Administrator finds that, because of the nature of the disability for which hospital care was provided, a longer period of outpatient care is required, then the Administrator may extend beyond 12 months the period of time for which such care is furnished to the veteran directly by the VA. With respect to veterans receiving outpatient post-hospital care on a fee basis at a private facility for a non-service-connected disability, such care at VA expense would be limited to 12 months in any event if alternative Federal reimbursement were reasonably available to defray substantially (but not entirely) the cost of such care after the first 12 months. Thus, under the amendment, outpatient post-hospital care could continue to be furnished beyond 12 months (1) at a VA facility if such care were determined by the Administrator to be required beyond 12 months' duration for the particular disability being treated; and (2) on a fee basis if the first condition were present and substantial Federal reimbursement from non-VA resources were not available.

Clause (7) of subsection (a) of section 104 amends section 612(f) (2) (authorizing outpatient or ambulatory medical services for any veteran with a service-connected disability rated at 80 percent or more) by substituting 50 percent for the current 80 percent, so that any veteran with a service-connected disability rated at 50 percent or more would be eligible for the full range of outpatient or ambulatory services at VA facilities.

The VA estimates that there are 102,000 veterans in the United States with service-connected disabilities (combined degree) rated at 50 percent; 112,000 with service-connected disabilities rated at 60 percent; and 70,000 rate at 70 percent. The amendment, therefore, would make approximately 284,000 more veterans eligible for total health care (including preventive health care under the amendment made by section 110 of the bill) in VA facilities, in addition to the approximately 152,000 veterans who now qualify for total care by virtue of a service-connected disability rated at 80 percent or more. However, treatments to the potential 284,000 new section 612(f) (2) beneficiaries would not be over and above the 14 million outpatient treatments currently provided but would be furnished as part of a redirecting of priorities and of resource utilization as required by clause (9) of section 104(a) of the Committee bill, described below.

Clause (8) of subsection (a) of section 104 amends section 612(f) (authorizing outpatient medical services for veterans seeking treatment for non-service-connected disabilities) to authorize such home

health services as the Administrator determines to be necessary or appropriate for the effective and economical treatment of a veteran's disability. These home health services would include improvements and structural alterations to the veteran's home, but (a) only as necessary to assure the continuation of treatment or provide access to the home or to essential lavatory and sanitary facilities, and (b) only to the extent that such improvements or alterations are minor in nature.

The amendment authorizes home health services for veterans suffering from non-service-connected disabilities under the same circumstances that such services are authorized for service-connected veterans under section 612(a) (as amended by section 104(a)(1) of the Committee bill) of title 38. Only insofar as the provision of home improvements or structural alterations is concerned does the nature of the veteran's disability become important. The Committee bill (in section 104(a)(1)) authorizes home improvements and structural alterations to aid in the treatment of a service-connected disability even when such projects are not minor in nature, so long as the cost of such a project does not exceed the cost of the average period of hospitalization in VA facilities (approximately \$2,200). A veteran seeking assistance from the VA for projects to aid in the treatment of a non-service-connected disability could, under section 104(a)(8) of the Committee bill, obtain such assistance only for projects of a minor nature (costing \$500 or less or partial reimbursement up to that amount).

Enactment of this provision will cost \$390,000 in fiscal year 1977.

Clause (9) of subsection (a) of section 104 adds at the end of section 612 a new subsection (i), the purpose of which is to establish a system of special priorities among veterans seeking outpatient services under section 612, as follows:

New subsection (i): Provides that, except in cases of medical emergencies which pose a serious threat to life or health (which cases, of course, would receive the most urgent priority), veterans would receive outpatient medical services in the following order of priority:

(1) Highest priority would be accorded to veterans seeking treatment for a service-connected disability.

(2) Veterans with service-connected disabilities rated at 50 percent or more would be accorded second priority.

(3) Veterans with service-connected disabilities rated below 50 percent or with readjustment problems diagnosed pursuant to section 612A (as added by section 105 of the Committee bill) would be accorded third priority.

(4) Catastrophically-injured veterans who are being furnished medical services under present section 612(g) would be accorded fourth priority over other non-service-connected veterans.

Last in priority would be veterans seeking treatment for non-service-connected disabilities not included in any of the priority categories listed above.

Subsection (b) of section 104 requires the Administrator to report annually to the Congress on the results of the regulations adopted by the VA to carry out the priorities for the furnishing of outpatient medical services established by the amendment made by subsection (a)(9) of this section of the Committee bill.

Section 105

Amends subchapter II of chapter 17 by adding a new section 612A establishing a program of readjustment professional counseling for any veteran (including family members under certain circumstances) who served in the Armed Forces after August 4, 1964.

Subsection (a) of section 105 adds a new section 612A ("Eligibility for readjustment professional counseling") in subchapter II of chapter 17, as follows:

New section 612A: Subsection (a) authorizes the Administrator to furnish initial readjustment professional counseling to any veteran who served in the Armed Forces since the beginning of the Vietnam era (a veteran with service after August 5, 1964) and who requests such counseling to assist in the readjustment to civilian life. Readjustment professional counseling would include a general mental and psychological assessment of the veteran, and reimbursement of travel expenses associated therewith in accordance with section 111 (as amended by section 101 of the Committee bill).

Subsection (b) provides that if, on the basis of initial counseling, a veteran is deemed to need mental health services, then such services would be provided on an outpatient basis (including counseling and discretionary mental health services for family members under the terms of section 601(6)(B) (as amended by section 102(2) of the Committee bill) where essential for the effective treatment of the veteran) provided the veteran met all eligibility requirements for post-hospital care under section 612(f)(1)(B) except that the initial counseling is deemed to satisfy the requirement of prior hospitalization. If the veteran is not eligible for such care and services, then the Administrator is required to provide appropriate referral services to assure, to the maximum extent practicable, that the veteran receives such care or services from facilities outside the VA.

Subsection (c) directs the Chief Medical Director to provide for the training of paraprofessional and lay personnel, in addition to professional personnel, and to make maximum use of these paraprofessional personnel, voluntary workers, and veteran students in the initial intake and screening activities under new section 612A.

Subsection (d) further directs the Administrator, in cooperation with the Secretary of Defense, to take all appropriate action under the outreach services program provided for in section 241 of title 38 to ensure that all veterans (and terminating service personnel) eligible for readjustment professional counseling are advised of their eligibility and encouraged to take full advantage of it.

All veterans with service after August 4, 1964, would be given at least 2 years from the date of enactment of this new section within which to request assistance. Veterans discharged or released from active duty on or after the enactment date of the new section, or less than 2 years before the enactment date, would be given 4 years following the date of their discharge within which to request assistance.

This provision is substantially similar in purpose to a provision which was passed in the Senate in S. 2108 (92d Congress) and in S. 284 (93d Congress).

Subsection (b) of section 105 amends the table of sections at the beginning of chapter 17 to reflect the addition of the new section 612A made by subsection (a) of this section of the bill.

Enactment of the provision in section 105 of the Committee bill will cost \$10.35 million in fiscal year 1977—\$7.94 million for readjustment professional counseling, and \$2.41 million for induced medical services relating to outpatient mental health care services.

Section 106

Amends section 613 (which establishes the Civilian Health and Medical Program of the Veterans' Administration, or CHAMPVA, contract-care program for certain veterans' dependents) to broaden the eligibility of survivors of a deceased veteran for contract medical care benefits under CHAMPVA. Under current law, a deceased veteran's widow or surviving children are eligible for medical care benefits under CHAMPVA only if the veteran died as the result of a service-connected disability. The amendment extends CHAMPVA coverage to the widow or surviving children of a veteran who, at the time of death, had a total and permanent disability resulting from a service-connected disability, regardless of whether it can be shown that the veteran died as a result of that disability. This extension of coverage would be synonymous with coverage under chapter 35 of title 38, War Orphans' and Widows' Educational Assistance, as provided in section 1701(a)(1)(A)(ii).

This amendment will extend CHAMPVA eligibility to less than 1,000 widows and surviving children not now eligible for CHAMPVA benefits, at a total additional cost of \$57,000 in fiscal year 1977.

Section 107

Amends section 618 of title 38 to provide express statutory authority for, and make several substantive changes in the operation of, the VA's compensated work-therapy programs.

Subsection (a) of section 107. Paragraph (1) and (2) make technical and conforming changes in existing section 618, so that the existing language, with some purely technical modifications, becomes subsection (a) of such section.

Subsection (a)(3) of section 107 inserts at the end of the present language in section 618 four new subsections, designated as subsections (b) through (e), respectively, as follows:

New subsection (b): Paragraph (1) authorizes the Administrator (upon recommendation of the Chief Medical Director) to enter into arrangements with sources outside the VA, including private industrial and commercial enterprises, for the provision of therapeutic work for remuneration for patients of VA hospitals and nursing homes and patient members in VA domiciliaries.

Paragraph (2) further authorizes the Administrator to enter into arrangements with non-profit entities for the provision of therapeutic work for remuneration for such patients (including domiciliary patient members), pursuant to such fiscal, accounting, management, recordkeeping, and reporting requirements as the Administration establishes with respect to the activities of the non-profit entity.

New subsection (c): Establishes a revolving fund for the purpose of carrying out the provisions of new subsection (b) of section 618.

Paragraph (1) provides that the fund shall be called the "Veterans' Administration Special Therapeutic and Rehabilitation Activities Fund".

Paragraph (2) requires the VA to deposit in or credit to this fund all moneys received under arrangements with for-profit and non-profit sources outside the VA under now subsection (b), and to pay out of the fund remuneration to participating VA patients at rates prescribed by the Administrator; and further requires that these rates of remuneration be not less than the wage rates specified in the Fair Labor Standards Act and the regulations prescribed thereunder.

Paragraph (3) makes available, for initial investment in the fund established by paragraph (1), a sum not to exceed \$2 million from funds appropriated for the medical care of veterans, and further requires that any balance in the fund at the end of each fiscal year in excess of estimated requirements for the ensuing two fiscal years be credited to that appropriation.

Paragraph (4) requires the Chief Medical Director to prepare an annual description of all activities carried out under the VA's compensated work-therapy programs, for inclusion in the annual report submitted to Congress under section 214 of title 38.

New subsection (d): Requires the Administrator to coordinate the rehabilitative services offered under section 618 with vocational rehabilitation and education benefits provided pursuant to chapters 31, 34, and 35 of title 38.

New subsection (e): Requires the rehabilitation services offered under section 618 to be provided to patients in accordance with the priorities set forth in new subsection (i) of section 612 (as added by section 104(a) (9) of the Committee bill).

Subsection (b) of section 107 authorizes the Administrator to settle outstanding VA claims against private non-profit corporations arising from the use of VA facilities and personnel as part of a therapeutic or rehabilitative work program.

Paragraph (1) authorizes the settlement of such claims, and the binding release of all claims against such corporations, on such terms and conditions, and in such amounts, as the Administrator deems appropriate.

Paragraph (2) permits the Administrator to utilize any funds recovered pursuant to such settlements for any purpose agreed upon by the Administrator and the corporation in question, notwithstanding the provisions of section 484 of title 31 (relating to the deposit into the Treasury of moneys received for the use of the United States).

Section 108

Makes several changes in section 620 (authorizing the furnishing of nursing home care in community facilities at VA expense) of title 38 to facilitate the transfer of veteran hospital patients to community nursing homes, and to authorize the transfer of certain veterans to community intermediate care facilities.

Clause (1) of section 108 makes a conforming change in section 620(a).

Clauses (2) and (3) of section 108 liberalize the cost formula for determining the maximum amount which the VA may pay for care in a community nursing home. Under current law, the VA may bear the expense of care in a community nursing home up to a rate for such care which does not exceed 40 percent of the cost of care furnished in an index VA general hospital. *Clause (2)* raises the percentage to

45 percent; the VA, therefore, would be authorized to pay for nursing home care in community nursing homes charging as much as 45 percent of the cost of hospitalization in the index VA hospital. *Clause (3)* permits the cost to rise as high as 50 percent where, as determined necessary by the Administrator upon the recommendation of the Chief Medical Director, the higher percentage is necessary to provide adequate care.

Clause (4) of section 108 makes a series of amendments in section 620(d) to authorize discretionary direct admission of veterans with non-service-connected disabilities to community nursing home facilities. Under existing law, direct admission is authorized only for veterans requiring nursing home care for a service-connected disability. This amendment permits the Administrator discretionarily to authorize direct admission of other veterans in accordance with the special priorities described in subsection (i) of section 612 (as added by section 104(a) (9) of the Committee bill) of title 38, and makes the necessary conforming amendments in section 620(d) of such title.

Enactment of this provision will result in a cost saving at \$5.26 million in fiscal year 1977.

Clause (5) of section 108 adds at the end of section 620 a new subsection (e), as follows:

New subsection (e): Defines "nursing home care", for purposes of section 620, to include "intermediate care" as the latter term is defined by the Administrator pursuant to regulation. The effect of the amendment is to permit the transfer of certain VA hospital patients to community intermediate care facilities (such facilities are presently eligible for reimbursement under the Social Security Act). The rate of reimbursement for such facilities would be determined by the Administrator; the rate is required to be commensurately less than the rate provided for skilled nursing home care (as defined in section 101(28)) under section 620(a) (as amended by clauses (1) through (3) of this section of the Committee bill).

Section 109

Amends subchapter V of chapter 17 to make changes in the VA's State veterans home program.

Paragraph (1) of subsection (a) makes technical and conforming changes in section 641, and permits reimbursement at the nursing-home-care rates for domiciliary care provided by a State home in any State which has no VA hospital or domiciliary facility within its boundaries.

Paragraph (2) of subsection (a) amends section 642 to permit the Administrator to stop or suspend per diem payments to any State home which fails to meet quality standards prescribed by the Administrator (which standards, with respect to nursing home care, are required to be as stringent as those prescribed for community nursing homes under section 620(b) of title 38).

Subsection (b) of section 109 makes a series of amendments to subchapter III of chapter 81, all designed to encourage and facilitate the construction of State home facilities in States without VA hospitals or domiciliary facilities.

Paragraph (1) amends section 5031 by (1) redesignating paragraphs (a) through (d) as (1) through (4), respectively; (2) amending the definition of "construction" in paragraph (3) (as so redesign-

nated) to make it clear that the remodeling, modification, or alteration of an existing building not presently used to provide nursing home care qualifies as "construction" for purposes of subchapter III; and (3) inserting a new paragraph (5) at the end of section 5031 to provide that in States in which no VA hospital or domiciliary facility is located, "nursing home care" includes domiciliary care.

Paragraph (2) amends section 5034 to require the Administrator to prescribe general standards for the furnishing of nursing home care in State facilities constructed with assistance of the VA under subchapter III. The standards are required to be as stringent as those prescribed by the Administrator for community nursing homes under section 620(b) of title 38 (except that, with respect to facilities providing domiciliary care pursuant to the definition in new paragraph (5) of section 5031 (as added by section 109(b)(1) of the Committee bill), the Administrator is required to prescribe new standards).

Paragraph (3) amends section 5035(a)(4) (which requires that the VA provide construction assistance only after receiving reasonable assurances that not more than 10 percent of the bed occupancy in the new State facility will consist of non-veteran patients) by adding at the end thereof "except as provided in subsection (c) of this section"; and amends section 5035(c) to waive the not-more-than-10-percent-non-veteran requirement for the construction of a facility in a State in which no VA hospital or domiciliary facility is located, and to authorize funding for the construction of a facility in such State if such State provides reasonable assurance that not more than such proportion as the Administrator deems reasonable (but in no case more than 50 percent) of the bed occupancy will consist of non-veterans.

Section 110

Amends chapter 17 of title 38 by adding a new subchapter VII establishing a comprehensive preventive health care program for eligible veterans.

Subsection (a) of section 110 amends chapter 17 by adding a new subchapter VII to provide for a preventive health care program for veterans with service-connected disabilities and to authorize the Administrator to carry out a pilot program (including research) on a geographical or other basis to determine the cost-effectiveness and medical advantages of furnishing comprehensive preventive health care services to veterans with service-connected disabilities. Under the amendment, four new sections are added to chapter 17, as follows:

New section 660: Describes the purpose of the new subchapter.

New section 661: Defines "preventive health care services" which may be included in such programs. Such services may include but are not limited to periodic medical and dental examinations; patient health education (including nutrition education); maintenance of drug use profiles, patient drug monitoring, and drug utilization education; mental health preventive services (including family counseling); substance (including tobacco) abuse prevention measures; immunizations against infectious disease; prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature; genetic counseling concerning inheritance of

genetically determined diseases; routine vision testing and eye care services; and periodic reexamination of high risk groups for selected diseases and for functional decline of sensory organs.

New section 662: Paragraph (1) of subsection (a) authorizes the Administrator, pursuant to regulations, to furnish on an inpatient, outpatient, or ambulatory basis, as part of medical services furnished under section 612 of title 38, such preventive health care services as are feasible and appropriate to any veteran in connection with the treatment of a service-connected disability and, in the case of a veteran suffering from a service-connected disability rated at 50 percent or more, such preventive health care services as are feasible and appropriate to ensure the best possible health care.

Paragraph (2) of subsection (a) authorizes the Administrator to institute controls and conduct followup studies (including research) to demonstrate the medical advantages and cost-effectiveness of the preventive health care services furnished under paragraph (1).

Subsection (b) authorizes the Administrator, pursuant to regulations, to carry out a health maintenance pilot program to demonstrate the medical advantages and cost-effectiveness of preventive health services. The pilot program is to begin on October 1, 1977, is limited to not more than 10,000 veterans with service-connected disabilities selected in accordance with the priorities in new subsection (i) of section 612 (as added by section 104(a) (9) of the Committee bill) of title 38, and has a 10-year lifetime.

Subsection (c) directs the Administrator to utilize interdisciplinary health care teams in carrying out such a preventive health care program which, to the maximum extent feasible, shall be composed of various professional and paraprofessional personnel, especially public health nurses, psychologists, optometrists, technicians, physician assistants, and expanded-function dental auxiliaries.

Subsection (d) authorizes the Administrator to conduct immunization programs for veterans as part of national immunization programs conducted by the Department of Health, Education, and Welfare. Veterans receiving care in a VA facility for any disability may be immunized as part of such a national program, and, notwithstanding any other provision of law, vaccine used by the VA for such a purpose may be provided to the VA at no cost by the Secretary of Health, Education, and Welfare and the VA's regular tort claims procedure under present section 8116 would apply to claims alleging malpractice or negligence on the part of VA personnel in connection with such program. This generic language derives from section 3 of H.R. 9811 as amended by the Senate on August 31, 1976, to authorize VA participation in the National Swine Flu Immunization Program of 1976 (P.L. 94-380).

New section 663: Directs the Administrator to include in the annual report to Congress, a comprehensive report on the administration of new subchapter VII, including recommendations for additional legislation deemed necessary.

Subsection (b) of section 110 amends the table of sections at the beginning of chapter 17 to add a reference to the new subchapter VII added to title 38 by section 110 of the bill.

Subsection (c) of section 110 provides that the programs authorized by the new subchapter VII except the health maintenance pilot pro-

gram shall be effective with respect to services furnished on and after January 1, 1977.

Enactment of the comprehensive preventive health care program set forth on section 111 of the Committee bill will cost \$6.19 million in fiscal year 1977.

Section 111

Amends section 1903(e) (directing the VA to carry out adaptive equipment driver training courses) of title 38 to permit the Administrator to provide automobiles and other conveyances for use in training courses at VA hospitals and selected regional offices and other medical facilities.

Under current law, the Administrator is required to provide such training courses to any veteran or member of the Armed Forces who is eligible, under sections 1901 and 1902, for assistance in purchasing an automobile or other conveyance or in equipping such automobile or conveyance with adaptive equipment. The Administrator may also provide training courses to veterans or members of the Armed Forces who are not eligible for such assistance, if the Administrator determines that the veteran or member needs the special training provided in such courses.

Clause (1) of section 111 makes a technical amendment in section 1903(e) (1) to relocate the reference to members of the Armed Forces after, rather than before, the reference to eligibility for care under chapter 17 of title 38. Current law creates the erroneous and unintended impression that members of the Armed Forces are entitled to care under chapter 17; the technical amendment corrects this drafting oversight.

Clause (2) of section 111 adds at the end of section 1903(e) a new paragraph (3) which authorizes the Administrator to obtain automobiles or other conveyances deemed necessary to carry out the special driver training courses authorized by section 1903(e). The Administrator is also authorized to sell, assign, transfer, or convey any such vehicle or conveyance to which the VA obtains title for such price and upon such terms as are deemed appropriate. Proceeds realized from the sale or disposition of such vehicles are credited to the applicable VA appropriation.

Section 112

Makes a series of amendments to subchapter I of chapter 73 of title 38 to shorten the probationary period from 3 to 2 years for health care personnel appointed under title 38, to define more clearly the procedural rights due full-time probationary and temporary, part-time, and intermittent employees (and interns and residents) whose employment the VA proposes to alter or terminate, and to define more clearly the procedural rights due an employee against whom disciplinary action is to be taken.

Clause (1) of subsection (a) of section 114 amends section 4106(b) (relating to appointments of probationary title 38 employees) of title 38 by inserting four new paragraphs as follows:

New paragraph (1): Reduces the probationary period of physicians, dentists, nurses, physician assistants, and expanded-function dental auxiliaries from 3 years to 2 years, and provides for periodic review of probationary employees by a board composed of employees.

A probationary employee found not fully qualified and satisfactory for reasons relating to professional competence or performance may have his or her appointment terminated, be reassigned, or be made subject to other nondisciplinary action, consistent with the employee's continued employment in a capacity in which such employee can effectively function.

New paragraph (2): Defines the probationary employee's rights when it is proposed to take action against the employee for reasons relating to professional competence or performance. Such employee would have the right, before any action is taken, to a written statement of supporting reasons and proposed findings with respect to professional competence or performance, an opportunity for the employee to reply either orally or in writing, or both, and assistance (not at Government expense) by a person of the employee's choice with regard to such reply.

New paragraph (3): Provides for review by the Chief Medical Director (in accordance with certain procedures specified in section 4110(e) as amended by subsection (a)(2) of this section) of any recommendation by a board that action be taken against a probationary employee.

New paragraph (4): Provides that when it is proposed to separate a probationary employee on grounds of misconduct or grounds which would result in stigma to the employee (rather than not full satisfactory professional competence or performance), such action shall be taken only in accordance with the procedures set forth in section 4110, as amended by subsection (a)(2) of this section.

Clause (2) of subsection (a) of section 114 revises section 4110 (relating to disciplinary boards) by rewriting and reorganized the section to include five revised and one new subsection, as follows:

Revised subsection (a): Provides that employees who have completed the probationary period—reduced from 3 to 2 years—or temporary, part-time, and intermittent employees, probationary employees, and residents and interns against whom disciplinary action on the grounds of misconduct or grounds which would result in stigma to the employee is proposed—come within the coverage of this section. The subsection continues to provide that the Chief Medical Director will appoint a disciplinary board to hear charges of ineptitude, inefficiency, misconduct or other such cause as will promote the efficiency of the service, as appropriate.

Revised subsection (b): provides that the board would consist of 3 to 5 employees (selected by the Chief Medical Director) of a grade comparable to or higher than that of the employee charged, and that a majority of the members of the board would be of the same profession as the employee charged.

Revised subsection (c): Provides that the Chief Medical Director would appoint the chairman of the board who would be a member of the same profession as the employee charged. The revised subsection also would provide that a secretary be elected by a majority of the board; and continues the provision in existing subsections (b) and (c) that both the chairman and secretary would be empowered to administer oaths and the Chief Medical Director would be authorized to designate or appoint one or more investigators to assist in the collection of evidence, and to appoint counsel to represent the Department of Medicine and Surgery.

Revised subsection (d): Provides that the employee charged is entitled to the basic elements of due process—a specification of charges, a full hearing with opportunity to produce supportive witnesses and confront and cross-examine available (those who are VA employees or those of another Federal department, agency, or instrumentality) witnesses, and representation (not at Government expense) by a person of the employee's choice throughout the process—all before any disciplinary action is effectuated.

Revised subsection (e): Provides that, when it finds a charge sustained, a disciplinary board would recommend such disciplinary action as it deems appropriate to the Chief Medical Director to include, but not be limited to, reprimand, suspension without pay, reassignment, reduction in grade, and separation. The Chief Medical Director would be given several options as to a charge sustained by the board. He could approve, approve with modification, or disagree with the board recommendation for disciplinary action as to a sustained charge. He could also take exception to a board finding as to a sustained charge. The Chief Medical Director would also be given the option of remanding the matter to the board for further consideration. If this were done and the Chief Medical Director still could not accept the findings and recommendations of the board as to a sustained charge; he could make an independent review of the record before making a final decision in the matter. The Chief Medical Director's decision would be the final agency decision, and would be provided to the employee in writing along with supporting reasons and explanations of any disagreement with or modification of a board recommendation as to a sustained charge.

New subsection (f): Provides certain remedies for employees who are reassigned (as defined in the new subsection to mean the transfer of an employee from one duty station to another or from one set of responsibilities to another, within the Department of Medicine and Surgery). Where reassignment is made after charges and a hearing, it is considered one of the remedies of the Chief Medical Director under subsection (e) as amended. The new subsection also permits non-disciplinary reassignments "for the good of the service" of an employee who has completed the probationary period prescribed in section 4106(b). If, however, any proposed reassignment would result in a reduction in grade, salary, or relative standing in the Department of Medicine and Surgery, the employee is entitled, before the reassignment is effectuated, to the full disciplinary board procedures of this section. When an employee alleges that a reassignment proposed "for the good of the service," not resulting in a reduction in grade, salary, or relative standing in the Department of Medicine and Surgery is punitive or disciplinary in nature, the employee is entitled to use the agency grievance procedure in seeking a determination that the allegation is correct, and to have the reassignment stayed pending resolution of the grievance. If the allegation is sustained, the employee is then entitled to the full disciplinary board procedures of this section.

Clause (3) of subsection (a) of section 112 amends section 4114(b) (relating to residents and interns) of title 38, by redesignating paragraphs (2) and (3) as paragraphs (3) and (4) and inserting a new paragraph (2), as follows:

New paragraph (2): Authorizes the Chief Medical Director to cause to be appointed House Staff Review Committees which will re-

view the academic and professional performance and progress of house staff. The procedures provided for in this new paragraph parallel those added to section 4106(b) of title 38 by subsection (a) (1) of this section of the Committee bill, by extending to residents and interns rights comparable to those extended to probationary employees under section 4106(b), with the exception of permanent status.

Subsection (b) of section 112 sets effective dates for the amendments made by subsection (a) of this section of the bill with respect to the period of probationary service under section 4106 of title 38. For probationary employees who, on the date of enactment of the bill, have served 18 months or more of their probationary period, the effective date is 180 days following the enactment date. For probationary employees with less than 18 months of service, the effective date is the enactment date.

Section 113

Amends section 4107 of title 38 to assist the Department of Medicine and Surgery in recruiting and retaining the services of health care personnel.

Clause (1) of section 113 inserts at the end of section 4107 a new subsection (g), as follows:

New subsection (g): Directs the Administration to raise the pay, on a nationwide basis, to the maximum permissible levels within grade for certain VA health care professionals when needed to recruit a scarce specialty due to high-paying competition or the remoteness of the VA facility. There is similar Government-wide authority reposing in the Civil Service Commission.

Enactment of this provision will cost \$1 million in fiscal year 1977.

Clause (2) of section 113 amends section 4114(b) (1) (relating to the establishment of residencies and internships) to permit the Administrator to establish pay rates for residents and interns retroactively, when the customary amount and terms of pay are changed. The purpose of this amendment is to ensure parity for VA residents and interns with their non-VA peers in the same hospital whose amounts and terms of pay may be adjusted retroactively.

Section 114

Makes a series of amendments to chapter 73 of title 38 to enhance the recruitment and retention of podiatrists and optometrists by establishing Podiatric and Optometric Services in the Department of Medicine and Surgery and making podiatrists and optometrists part of the title 38 personnel and pay system.

Clause (1) of section 114 amends section 4102 (relating to the organization of the Department of Medicine and Surgery) to establish Podiatric and Optometric Services in the Department.

Clause (2) of section 114 amends section 4103 (relating to the office of the Chief Medical Director) to establish the positions of Director of Podiatric Service and Director of Optometric Service, appointed by the Administrator and responsible to the Chief Medical Director for the operation of their respective services.

Clause (3) of section 114 amends section 4104 (relating to the appointment of additional health care personnel in the Department of Medicine and Surgery) to remove podiatrists and optometrists from section 4104(2)—the list of Civil Service personnel—and place them

in section 4104(1)—the list of personnel appointed and paid under title 38.

Clause (4) of section 114 amends section 4105 (relating to the formal qualifications of appointees) to establish, as a new clause (5) in such section, the formal professional qualifications for appointment as a podiatrist—a degree of doctor of podiatric medicine, or its equivalent, from a school of podiatric medicine approved by the Administrator, and licensure to practice podiatry in a State.

Clause (5) of section 114 makes conforming amendments in section personnel) to reflect the addition of podiatrists and optometrists to optometrists appointed under section 4104(1) (as amended by clause (3) of this section).

Clause (6) of section 114 amends section 4107 (relating to the grades and pay scales of title 38 personnel) to (1) establish statutory rates of pay for the position of Director of Podiatric Service created by clause (1) of this section, and (2) establish a new pay schedule (the "Clinical Podiatrist and Optometrist Schedule") for podiatrists and optometrists appointed under section 4101(1) (as amended by clause (3) of this section).

Clauses (7), (8), (9), (10), and (11) of section 114 make conforming changes in sections 4108 (relating to personnel administration), 4112 (relating to the membership of the Special Medical Advisory Group), 4113 (relating to the travel expenses of title 38 personnel), 4114 (relating to temporary appointments in the Department of Medicine and Surgery), and 4116 (relating to the liability of title 38 personnel for malpractice or negligence), respectively, to reflect the addition of podiatrists and optometrists to the list of title 38 employees.

Clause (12) of section 114 makes conforming amendments in section 4117 (relating to contracts for scarce medical specialist services) to add appropriate references to podiatrists, optometrists, and schools of podiatry and optometry. The amendment also adds references to schools of osteopathy, nursing, and dentistry (current law refers only to schools of medicine among the many kinds of academic institutions with which contracts for scarce medical specialist services may be entered into).

Administrative and other costs associated with the enactment of the provisions in section 114 of the Committee bill will be \$690,000 in fiscal year 1977.

Section 115

Amends chapter 73 of title 38 by adding at the end a new subchapter to promote the protection of patient rights in VA facilities.

Subsection (a) of section 115 adds a new subchapter III—"Protection of Patient Rights"—at the end of chapter 73. The new subchapter contains four new sections, as follows:

New section 4131: Requires the Administrator (upon the recommendation of the Chief Medical Director, and pursuant to regulations) to establish procedures to ensure the full and informed consent of all subjects prior to the carrying out of any medical or prosthetic research or, to the maximum extent practicable, the furnishing of any patient care to patients.

New section 4132: Provides for the general confidentiality of drug and alcohol abuse treatment medical records, and describes the cir-

cumstances under which the contents of such records may be disclosed. The provisions are virtually identical, except for subsection (b) (3) (described in point (5) below), to the provisions in those existing laws of general applicability which would be superseded by virtue of section 115(c) of the Committee bill. This provision is substantially similar to a provision which was passed in the Senate in S. 2108 (92d Congress) and in S. 284 (93d Congress).

Subsection (a) of new section 4132 provides that records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with drug abuse, alcoholism or alcohol abuse, or sickle cell anemia programs or activities (including education, training, treatment, rehabilitation, or research as to any such program of activity) carried out by or for the VA are (except as provided in subsection (e)) confidential, and may be disclosed only as expressly authorized under subsection (b).

Subsection (b) of new section 4132 authorizes the release of information from confidential medical records under the following circumstances as to VA patients (including research subjects) in the covered programs: (1) To anyone designated by the patient, so long as the patient has given prior written consent and the information is released under circumstances and for purposes specified in regulations prescribed by the Administrator (new subsection (b) (1)); (2) to medical personnel in bona fide medical emergencies (new subsection (b) (2) (A)); (3) to qualified personnel for research, audit, or evaluation purposes, so long as the individual patients' identities are not disclosed (new subsection (b) (2) (B)); (4) pursuant to an appropriate order of a United States court of competent jurisdiction (the present law would permit a State court to order release of a VA medical record under the same specified circumstances), but only if the court considers the adverse impact of such disclosures on the patient and on the physician-patient relationship, and only if it imposes appropriate safeguards against unauthorized disclosure (new subsection (b) (2) (C)); or (5) to anyone designated by the next of kin, executor, administrator, or other personal representative of a deceased patient, if the request for the release of the information is in writing and is necessary for purposes of obtaining benefits to which the requesting survivor may be entitled, and if the release is under circumstances and for purposes specified in regulations prescribed by the Administrator (new subsection (b) (3)). The circumstances described under point 5, above, are in addition to those set forth in section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended (21 U.S.C. 1175) and section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended (42 U.S.C. 4582).

Subsection (c) of new section 4132 prohibits the use of confidential medical records to initiate or substantiate criminal charges against a patient or to conduct an investigation of a patient, except when such charges or investigations are authorized by a United States court order granted under new section 4132(b) (2) (C).

Subsection (d) of new section 4132 provides that the prohibitions against the release of information from confidential patient records continue to apply to the records of any patient or former patient, regardless of whether or when such person ceased to be a patient.

Subsection (e) of new section 4132 provides that the confidentiality requirements of this section do not prevent the interchange of records between VA health care facilities or with the Armed Forces

Subsection (f) of new section 4132 subjects violators of the confidentiality provisions of this section to criminal liability and fines.

New section 4133: Prohibits discrimination against alcohol and drug abusing eligible veterans who seek admission to a VA health care facility for the treatment of a medical disability, and requires the Administrator to prescribe regulations for the enforcement of this nondiscrimination policy. The provisions are virtually identical to provisions in section 407(a) of the Drug Abuse Office and Treatment Act of 1972, as amended (21 U.S.C. 1174), and section 321(a) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended (42 U.S.C. 4581). These provisions would be superseded by virtue of section 115(c) of the bill.

New section 4134: Subsection (a) requires the Administrator, in prescribing regulations for the protection of patient rights, to coordinate the regulations with existing regulations on the protection of patient rights prescribed by the Secretary of Health, Education, and Welfare, and to make these latter regulations applicable, to the maximum extent feasible consistent with the provisions of title 38, to the conduct of research and the provisions of health care and medical services in the VA. To achieve the maximum possible coordination of regulations, the Administrator is required to consult from time to time with the Secretary of Health, Education, and Welfare (and, as appropriate, the Director of the Office on Drug Abuse Policy or successor authority). As to confidentiality of records (to be covered by new section 4132) and nondiscrimination in admissions policies (to be covered by new section 4133), this coordination of regulations requirement is already required by law (section 333(h) of the 1970 Act and section 408(h) of the 1972 Act with respect to confidentiality of records, and section 122(c) of the 1974 Act and section 407(b)(2) of the 1972 Act with respect to nondiscrimination in admissions policies, the provisions of which would be superseded by subsection (c) of section 115 of the bill). As to informed consent, the similar requirement proposed in subsection (a) of new section 4134—that the Administrator seek to follow those regulations prescribed by the Secretary of Health, Education, and Welfare, based on the recommendations of the National Commission for the Production of Human Subjects of Biomedical and Behavioral Research, established by section 201 of the National Research Act (Pub. L. 93-348)—is a new one which derives from the same theory that maximum efforts ought to be made to achieve Government-wide coordination of certain matters affecting patient rights, while at the same time preserving the independent final decisionmaking authority of the Administrator and the Chief Medical Director with respect to VA health care activities and policies.

Subsection (b) of new section 4134 requires the Administrator to submit a full report to the appropriate committees of the Congress within 60 days after the date of enactment of the subsection with respect to all regulations prescribed pursuant to new section 4134(a), explaining any inconsistencies between such regulations and the regulations of the Secretary of HEW, outlining the extent, substance, and results of consultations with the Secretary (or, as appropriate,

the Director of the Office on Drug Abuse Policy, or successor authority), and recommending necessary and desirable legislation and administrative actions. The Administrator is required to publish the report required by this subsection in the Federal Register. By virtue of section 115(c) of the Committee bill, the existing comparable provisions (sections 122(c) and 303(c) of the 1974 Act, section 121(b) of the 1970 Act, and section 6(b) of Public Law 94-237) would be superseded.

Subsection (b) of section 115 makes conforming amendments to the analysis at the beginning of chapter 73, to make reference to the new subchapter III and new sections 4131 through 4134 added to the chapter by this section of the Committee bill.

Subsection (c) of section 115 provides for the supercession of existing laws making applicable to the VA general provisions respecting the protection of patient rights. The applicability of these general provisions would no longer be required if (as would be provided by subsection (a) of this section of the Committee bill) title 38 included provisions to protect these rights of patients in VA health care facilities. The existing statutory provisions that would be generally or specifically superseded are:

(1) Section 321(b)(2) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4581(b)(2)), as added by section 121(a) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (Public Law 93-382) (requiring the Administrator of Veterans' Affairs to prescribe regulations making applicable to admission to VA hospitals the proscription against discrimination against alcohol abusers and alcoholics contained in section 321(a) of the 1970 Act, as amended);

(2) Section 407(b)(2) of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1174(b)(2)), as added by section 6(a) of an Act entitled "An Act to amend the Drug Abuse Office and Treatment Act of 1972, and for other purposes", approved March 19, 1976 (Public Law 94-237) (requiring the Administrator of Veterans' Affairs to prescribe regulations making applicable to VA medical programs the nondiscrimination provisions against drug abusers contained in section 407(a) of the 1972 Act, as amended);

(3) Section 408(h) of the 1972 Act (21 U.S.C. 1175(h)), as added by section 303(a) of the 1974 Act (requiring the Administrator to prescribe regulations making applicable to the drug abuse treatment medical records maintained by the VA the confidentiality requirements contained in section 408 of the 1972 Act, as amended);

(4) Section 333(h) of the 1970 Act (42 U.S.C. 4582(h)), as added by section 122(a) of the 1974 Act (requiring the Administrator to prescribe regulations making applicable to the alcoholism treatment medical records maintained by the VA the confidentiality requirements contained in section 333(a) of the 1970 Act, as amended by the 1974 Act);

(5) Section 121(b) of the 1970 Act (requiring the Administrator to submit reports to Congress on regulations adopted in

coordination with the Secretary of Health, Education, and Welfare with regard to the provisions on nondiscrimination against alcoholics and alcohol abusers contained in section 321(a) of the 1974 Act);

(6) Section 6(b) of Public Law 94-237 (requiring the Administrator to submit reports to Congress on regulations adopted with regard to the provisions on nondiscrimination against drug abusers contained in section 407(a) of the 1972 Act, as amended);

(7) Section 303(c) of the 1974 Act (requiring the Administrator to submit reports to Congress on regulations adopted in coordination with the Secretary of Health, Education, and Welfare with regard to the provision on confidentiality of drug abuse medical records contained in section 408(h) of the 1972 Act, as amended); and

(8) Section 122(c) of the 1974 Act (requiring the Administrator to submit reports to Congress on regulations adopted in coordination with the Secretary of Health, Education, and Welfare with regard to the provision on the confidentiality of alcoholism treatment medical records maintained by the VA).

Section 116

Amends section 4118 (relating to the special pay program for physicians and dentists) of title 38 to expand eligibility for special pay and to extend the program for an additional 11½-month period.

Subsection (a) of section 116 amends paragraphs (1) and (3) of section 4118(a) so as to require the payment of special pay to eligible clinical researchers in the Department of Medicine and Surgery's career development program. Since the enactment of the special pay program in October, 1975, the approximately 150 full-time VA physicians and dentists who serve as clinical researchers have been administratively excluded from eligibility for special pay pursuant to section 4118(a)(3), which permits the Chief Medical Director to designate categories of positions as to which in his judgment there is no significant recruitment or retention problem and exclude those categories from special pay eligibility. The Committee bill mandates the payment of special pay to clinical researchers who are otherwise eligible to receive it by (1) authorizing special pay under section 4118(a)(1) for physicians and dentists serving in any of three capacities—professional, administrative, or clinical research—and (2) permitting administrative exclusion from eligibility under section 4118(a)(3) only of physicians and dentists in the former two categories. The effect of the amendments contained in clauses (1) and (2) of subsection (a) of this section is to remove the Chief Medical Director's discretionary authority to exclude clinical researchers from special pay eligibility, and thereby to require the payment of special pay to otherwise eligible physicians and dentists serving in a clinical research capacity.

Subsection (b) of section 116 extends until September 30, 1977 (by reference to the date on which the military special pay program (37 U.S.C. 313) expires) the special pay program, which, under section 6(a)(2) of Public Law 94-123 (the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975), is due to expire on October 11, 1976.

Enactment of the special pay provisions in section 116 of the Committee bill will cost \$4.28 million in fiscal year 1977.

Section 117

Amends section 4123 (relating to personnel eligible for training at Regional Medical Education Centers under subchapter II of chapter 73) of title 38 to provide authority to credit proceeds received through the training of non-VA health care personnel to the applicable VA medical appropriation, Medical Administration and Miscellaneous Operating Expenses. Under current law, non-VA health care personnel are eligible for in-residence training at the VA's Regional Medical Education Centers, to the extent that facilities are available. Non-VA personnel must provide full reimbursement to the VA for training and related services provided at the Centers.

Section 118

Amends chapter 75 of title 38 to make changes in the budgeting and bookkeeping requirements of the Veterans Canteen Service.

Clause (1) of section 118 would amend section 4204 (relating to financing of the Canteen Service) by making the current language subsection (a) and inserting a new subsection (b), as follows:

New subsection (b): Authorizes the Canteen Service to incur obligations in excess of budgetary resources. Under existing law and regulations, the Veterans Canteen Service is required to maintain sufficient capital to fund outstanding obligations at all times during the year. Since it is necessary to place merchandise orders in the first fiscal year quarter, the Canteen has, for several years, reflected an over-obligation balance during the first fiscal year quarter, a technical violation of the Anti-deficiency Act (31 U.S.C. 665). The amendment would give the Canteen Service authority to incur obligations in excess of budgetary resources. Under new subsection (b), the Canteen Service would still be required to be administered on a sound fiscal basis from year to year.

Clause (2) of section 118 would amend section 4206 (relating to the budget of the Canteen Service) to delete the first and last reference to "year" and to insert a reference to "five fiscal years". The proposed change would permit multi-year budget planning to prevent unanticipated deficits from being incurred. (The Canteen Service is precluded by law from borrowing funds to meet such deficits.) Under existing section 4206, the Veterans Canteen Service is required to prepare annually and submit a budget program containing an estimate of the needs of the Service for the "ensuing fiscal year" including an estimate of the amount required to restore any impairment of the revolving fund resulting from operations of the current fiscal year. The law requires also that any balance in the revolving fund at the close of the fiscal year in excess of the estimated requirements for the ensuing fiscal year shall be covered into the Treasury as miscellaneous receipts. The word "year" instead of "years" was inadvertently included in the enabling legislation in 1946.

The amendment would also add a new sentence at the end of section 4206 to authorize the Veterans Canteen Service to use the revolving fund and its own proceeds to provide capital improvements to canteen facilities, including items which are constructed and become a part of the building or structure, subject to the approval of the Office

of Management and Budget and to the extent specified in the President's annual budget.

Section 119

Amends section 5001(a)(3) (relating to the provision of nursing home care beds) of title 38 to continue the expansion of the VA's nursing home care program. Under current law, the VA is required to operate not less than 8,000 nursing home care beds. The amendment would require the Administrator (subject to the approval of the President) to carry out the VA's present plan to establish and operate a minimum of 10,000 nursing home care beds by fiscal year 1980 and in each succeeding fiscal year.

Section 120

Amends subchapter IV of chapter 81 (relating to the Sharing of Medical Resources) of title 38.

Clause (1) of subsection (a) of section 120 amends the definition of "specialized medical resources" contained in section 5052(d) to include emergency room medical resources necessary for the treatment of an eligible veteran (for a service-connected disability or for a non-service-connected disability when the veteran has a 50-percent-or-more-rated service-connected disability or is seeking post-hospital care on an outpatient basis in medical emergencies which pose a serious threat to life or health. The amendment authorizes the contractual use of community emergency room medical resources when such resources would be unduly costly and duplicative to provide directly in a VA facility.

Clause (2) of subsection (a) of section 120 amends section 5053 (relating to specialized medical resources) by adding a new subsection (d) at the end thereof, as follows:

New subsection (d): Provides that where services are provided a medicare beneficiary pursuant to an agreement authorized by section 5053, reimbursement for such benefits shall be paid to the VA facility, or if the agreement provides, to the community health care facility which is a party to the contract or agreement, in accordance with rates prescribed by the Secretary of Health, Education, and Welfare after consultation with the Administrator, and with procedures jointly prescribed by the Secretary and the Administrator to assure reasonable quality of care and services and efficient utilization of resources. This amendment would permit the Secretary and the Administrator to develop reasonable procedures and standards governing reimbursement, utilization, and quality assurance without regard to strict Social Security Administration requirements applied to non-Federal providers under Medicare and the End-Stage Renal Disease Program.

Clause (3) of subsection (a) of section 120 amends section 5056 (relating to coordination with HEW programs formerly carried out under title IX of the Public Health Service Act) to conform the reference to new comparable programs carried out under newly enacted (by the National Health Planning and Resources Development Act of 1974, Pub. L. 93-641) part of F of title XVI of the Public Health Service Act.

Clause (4) of subsection (a) of section 120 adds two new sections to subchapter IV of chapter 81, as follows:

New section 5058: Subsection (a) directs the Administrator and the Secretary of HEW to attempt to coordinate the Professional Standards Review Organization (PSRO) program carried out pursuant to part B of title XI of the Social Security Act, and comparable programs carried out by the Department of Medicine and Surgery and provides that such coordination shall include sharing of information with regard to norms of health care services developed on a regional and national basis and arrangements for joint memberships on entities established under the two programs.

Subsection (b) directs the Chief Medical Director to report to Congress annually on the effectiveness of the coordination achieved pursuant to subsection (a) of the new section in improving the evaluation of the quality of patient care provided by the Department of Medicine and Surgery and in achieving the purposes of the PSRO program carried out under the Social Security Act.

New section 5059: Directs the Chief Medical Director, through the Administrator, to report to Congress on all activities (and the results thereof) in which the Chief Medical Director or a designee, as a representative of the VA, has participated in an advisory or coordinating capacity with respect to programs carried out by other departments, agencies, or instrumentalities of the executive branch. The following is a partial list of statutory authorities establishing an advisory or cooperative role for the VA hospital and medical program:

- (1) The National Cancer Act of 1971 (Pub. L. 92-218).
- (2) The Drug Abuse Office and Treatment Act of 1972 (Pub. L. 92-255).
- (3) The National Heart, Blood Vessel, Lung, and Blood Act of 1972 (Pub. L. 92-423).
- (4) The Emergency Medical Services Systems Act of 1973 (Pub. L. 93-154).
- (5) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (Pub. L. 93-282).
- (6) The Research on Aging Act (Pub. L. 93-296).
- (7) The Health Services Research, Health Statistics, and Medical Libraries Act of 1974 (Pub. L. 93-353).
- (8) The National Arthritis Act of 1974 (Pub. L. 93-640).
- (9) The National Health Planning and Resources Development Act of 1974 (Pub. L. 93-641).

Subsection (b) of section 121 amends the table of sections at the beginning of subchapter IV to reflect the conforming changes made in inserting of the new subsection (e) in such section, as follows: which would be added to title 38 by section 121 of the Committee bill.

Section 121

Amends chapter 82 of title 38 to make minor changes in the circumstances and conditions under which the VA provides support to affiliated medical schools and other health care personnel training institutions.

Clause (1) of section 121 amends section 5070 by inserting a new subsection (e) and redesignating subsections (e) and (f) of section 5070 as subsections (f) and (g), respectively, to conform with the inserting of the new subsection (e) in such section, as follows:

New subsection (e): Incorporates the provisions now contained in section 5073(a)(1). These provisions permit the Administrator to lease land, buildings, and structures under the control and jurisdiction of the VA to an eligible medical institution, under terms and conditions deemed appropriate by the Administrator, without regard to limitations on the terms of such a lease imposed by other provisions of law. Under current law, such leasing authority, contained in section 5073(a)(1), applies only with respect to grants to medical schools participating in the pilot program for assistance in the establishment of new State medical schools under subchapter I of Chapter 82. By moving these provisions to section 5070—which applies to all of chapter 82—the Administrator's leasing authority is broadened to include leasing arrangements with affiliated existing medical schools under subchapter II, and with institutions of higher learning, hospitals, and other health care personnel institutions under subchapter III of chapter 82.

Clause (2) of section 121 adds a new subsection (h) at the end of section 5070, requiring the Administrator to submit an annual report to the Congress on all activities carried out under chapter 82. The reports would be due no later than 90 days after the end of each fiscal year.

Clause (3) of section 121 strikes out section 5073(a)(1)—the provisions of which, under the amendments in clause (1) of this section of the bill, would be relocated as new section 5070(e)—and redesignates paragraphs (2) and (3) of section 5073(a) as paragraphs (1) and (2), respectively.

Clause (4) of section 121 changes a reference in section 5073(b)(2) to reflect the amendments made by clause (1) of this section.

Section 122

Encourages and facilitates short-range and long-range planning for the adaptation of current VA hospital, nursing home, domiciliary, and medical service capacity to accommodate the growing number of elderly veterans in the United States and the increasing average age of the eligible veteran population; and ensures notification of all individuals eligible for new or expanded care or services as a result of the amendments made by the Committee bill of the changes in eligibility made by the Committee bill.

Subsection (a) of section 122 requires the Chief Medical Director to carry out or provide for a study to determine the short-range and long-range direction of the title 38 health care program in light of the increasing average age of the eligible veteran population. The report is required to include specific plans for adjusting the VA's capacity to provide hospital, nursing home, intermediate and domiciliary care beds; adjusting the contract community nursing home program; improving the quality of health care for elderly veterans through the education and training of specialized geriatric health care personnel and through research designed to ameliorate geriatric care problems; expanding alternatives to institutional care; dealing with the special architectural, transportation, and environmental needs of an aging population; and emphasizing treatment programs particularly suited to the health care needs of an aging population. The Chief Medical Director, through the Administrator, is required to submit this report

to the House and Senate Committees on Veterans' Affairs no later than 12 months after the date of enactment of the bill.

Subsection (b) of section 122 requires the Administrator, within 90 days of the effective date of this Act, to take all appropriate steps (to the maximum extent feasible) to ensure that each individual eligible for new or expanded care and services as a result of the amendments made by this Act is personally, clearly, and simply notified to that effect. The Administrator is also required to send copies of all such notification forms, and descriptions of the manner in which such forms were distributed, to the appropriate committees of the House of Representatives and the Senate.

TITLE II—VETERANS DRUG AND ALCOHOL TREATMENT AND REHABILITATION AMENDMENTS

Section 201

Establishes the short title of this title of the Committee bill as the "Veterans Drug and Alcohol Treatment and Rehabilitation Act of 1976".

Section 202

Amends section 601(1), which defines the term "disability" for purposes of chapter 17 (Hospital, Domiciliary and Medical Care) of title 38, to include "alcoholism and drug dependence" within the meaning of "disease". An identical provision was passed by the Senate in S. 2108 (92d Congress) and S. 284 (93d Congress).

Section 203

Establishes a special program for the treatment and rehabilitation of veterans suffering from alcoholism. A substantially similar provision was passed by the Senate in S. 2108 and S. 284.

Subsection (a) amends subchapter II of chapter 17 by adding a new section 620A, as follows:

New section 620A: Subsection (a) states a Congressional finding and declaration of the seriousness of alcoholism and alcohol abuse in the Nation, including among the veteran population.

Subsection (b) directs the Administrator to carry out on a nationwide basis, specialized medical programs providing inpatient and outpatient treatment and rehabilitative services (as defined in new paragraph (8) added to present section 601 by section 102(4) of the Committee bill) and including treatment of the symptoms of detoxification, to veterans eligible for chapter 17 medical care who are suffering from alcoholism or alcohol abuse. The Administrator is further directed to stress the use in such program of recovered alcoholic counselors, half-way houses, encounter-style therapeutic communities, and other treatment modalities in a comprehensive program ranging from detoxification to recovery. The Administrator is also authorized to utilize either facilities over which the Administrator has direct jurisdiction, or private half-way-house facilities for which the Administrator contracts in accordance with regulations. Finally, the Administrator is authorized to provide treatment and rehabilitative services to veterans, at VA expense (up to costs deemed reasonable by the Administrator, in community facilities approved by the Administrator whenever (1) a member of the veterans immediate family is

also suffering from alcoholism or an alcohol-related problem, (2) it is deemed essential to the successful treatment and rehabilitation of the veteran that the veteran and the family member be treated together in the same program, and (3) the veteran and the immediate family member have been accepted for treatment in the community facility.

Subsection (c) requires an annual report regarding the specialized alcohol abuse programs carried out under the new section, in the same detail as required (in new section 677) for implementation of the new subchapter VIII on drug dependence or abuse treatment and rehabilitation, as added by section 204 of the Committee bill.

Subsection (b) of section 203 amends the table of sections at the beginning of chapter 17 to add a reference to the new section 620A added to title 38 by subsection (a) of section 203 of the Committee bill.

Section 204

Amends chapter 17 of title 38 to establish a comprehensive program for the treatment and rehabilitation of veterans suffering from drug addiction and related drug abuse disabilities. Substantially similar provisions were passed by the Senate in S. 2108 and S. 284.

Subsection (a) of section 204 amends chapter 17 by adding a new subchapter VIII ("Special Medical Treatment and Rehabilitative Services for Drug Dependence or Drug Abuse Disabilities"), consisting of seven new sections, as follows:

New section 671: Establishes a definition of the term "veteran" for purposes of this new subchapter and thereby establishes eligibility for treatment and services under such subchapter for any person discharged from active military service with other than a dishonorable discharge (except as provided in section 3103 of title 38) who has a drug dependence or a drug abuse disability (hereinafter referred to as drug disabilities) without any need for a finding of service-connection in connection with such disability. Under the new definition, any veteran holding a discharge other than a dishonorable discharge—thus any veteran with an honorable, general, undesirable, or bad conduct discharge—would initially be eligible for treatment provided that the veteran was not discharged under the conditions described in section 3103 of title 38 (which disqualifies among other things, all discharges given by a general court martial).

New section 672: Sets forth the basic provisions governing the provision of treatment and rehabilitative services for veterans suffering from drug disabilities.

Subsection (a) directs the Administrator to furnish any veteran suffering from drug disabilities with such special medical treatment and rehabilitative services or hospital and domiciliary care as is reasonably necessary to effect the veteran's recovery and rehabilitation.

Subsection (b) specifies that treatment and rehabilitative services under the new subchapter shall include (in addition to those services described in the definitions of hospital care, medical services, and rehabilitative services set forth in section 601) individual counseling and referral services and crisis intervention. The subsection also specifies that such treatment and services shall be made available in VA directly-administered hospitals, domiciliary facilities, outpatient clinics, and half-way house and other community-based facilities,

as well as private half-way-houses under contract with the Administrator. Finally, the subsection authorizes treatment, at VA expense, in contract community facilities when a member of a veteran's immediate family suffers from a drug abuse problem, under the same circumstances described *supra*, in the analysis of new section 620A(b) as added by section 203(a) of the Committee bill.

Subsection (c) directs the Administrator to offer alternative modalities of treatment to each such veteran receiving treatment and rehabilitative services under the new subchapter (whether in VA or private facilities) and specifies that the alternatives offered shall be based upon the individual needs of each such veteran.

Subsection (d) directs the Administrator, in contracting for treatment and services under the new subchapter, to give the greatest feasible priority to community-based, multiple-modality programs employing peer-group veterans, and to include in such contractual arrangements the carrying out of maximum outreach efforts to identify and counsel veterans eligible under the new subchapter.

Subsection (e) directs the Administrator, upon receiving an application for treatment and services under the new subchapter from a veteran with an other than honorable or general discharge, to (1) advise the veteran of his right to apply to the appropriate military service to obtain a review of the nature of his discharge with a view toward removing any bar to eligibility for the receipt of veterans benefits under title 38; (2) advise the veteran of the current military policy regarding a review of discharges received in connection with drug abuse offenses; and (3) advise the veteran of all programs under title 38 and any other law to which the veteran is or would be entitled if the veteran had a general or honorable discharge. The subsection also directs the Administrator to offer any veteran within the coverage of the new subsection—and, if requested, to provide—all appropriate assistance needed to facilitate the process of preparing and filing with the military an application for a review of the nature of the veteran's discharge.

Subsection (f): Paragraph (1) directs the Administrator to provide for treatment and rehabilitative services in the case of any veteran eligible under the new subchapter who has been charged with, or convicted of, a criminal offense by any court of competent jurisdiction in the United States, who is not confined, and who is not required to participate in the treatment and rehabilitation by such court.

Paragraph (2) authorizes the Administrator to provide (either in VA-directly-administered facilities or programs or those under contract) for treatment and services to any veteran eligible under the new subchapter who has been criminally charged or convicted and who is required to participate in a treatment and rehabilitation program by a court of competent jurisdiction, but only under such conditions as the Administrator determines, on a case-by-case basis, will insure that the veteran's participation in the particular program will not impair the voluntary nature of the services provided other patients in such program.

New section 673: Subsection (a) directs the Administrator to utilize all VA resources to seek out and counsel toward treatment and rehabilitation all veterans eligible under the new subchapter, especially veterans who served after August 4, 1964.

Subsection (b) directs the Administrator to take affirmative steps, in consultation with the Secretary of Labor and the Chairman of the Civil Service Commission, to urge all Federal agencies, private and public firms, and persons to provide maximum employment opportunities for veterans provided treatment and rehabilitative services under the new subchapter and under the new section 620A (as added by section 203(a) of the Committee bill) who are determined to be sufficiently rehabilitated to hold gainful employment, and to provide all possible assistance to the Secretary of Labor in placing such veterans in such employment opportunities.

New section 674: Subsection (a) establishes the right of the Comptroller General of the United States, for the purposes of audit, to have access to all books, records, documents, things, or property of non-VA facilities carrying out treatment or rehabilitation programs under the new subchapter.

Subsection (b) directs the Comptroller General to carry out the GAO audit responsibilities so as to comply with the provisions respecting medical confidentiality set forth in new section 4132, which would be added by section 115(a) of the Committee bill.

New section 675: Requires a line item in the President's annual budget submission showing the estimated VA expenditures under the new subchapter and under new section 620A (regarding alcoholism treatment and rehabilitation) which would be added by section 203(a) of the Committee bill.

New section 676: Establishes procedures and requirements regarding the transfer, and treatment therein, of active-duty service personnel to VA health care facilities in connection with a drug disability.

Subsection (a) provides for the transfer of a member of the active military, naval, or air service with a drug disability to a VA medical facility for treatment pursuant to mutually agreed upon terms between the Secretary of the military department concerned and the Administrator and subject to reimbursement by such department. Such transfers are authorized only within the last 30 days of a tour of duty. After such a transfer, such individual would receive treatment and rehabilitative services on the same terms and conditions as prescribed for a veteran in the new subchapter.

Subsection (b) requires the Administrator to report periodically to the Secretary of the military department concerned regarding the progress of the treatment of each such individual transferred, and to release an individual back to the Secretary concerned when the Administrator finds that the disability is stabilized or certifies that such individual is refusing to comply with reasonable terms and conditions of treatment or that treatment would otherwise no longer be beneficial to such individual.

Subsection (c) prohibits transfers under new section 676 unless the individual in question specifically requests transfer for a specified period of time within the remaining tour of duty and does so in writing, and further prohibits the extension of such treatment beyond such specified period of time unless the individual specifically requests a specified extension and such request is approved by the Secretary and the Administrator.

New section 677: Requires the Administrator to submit to the Congress 6 months after enactment and thereafter on each May 1

a report on the implementation of the new subchapter and new section 620A (regarding alcoholism treatment and rehabilitation) which would be added by section 203(a) of the bill, broken down separately with respect to alcoholism and drug abuse disabilities, and an evaluation of the effective alternate treatment and rehabilitation modalities provided under the new subchapter and under new section 620A. The report will also include (1) numbers of patients treated, (2) average duration of treatment, (3) estimates of successful rehabilitation and recovery, (4) an analysis of rehabilitation experience, (5) a description of outreach and employment assistance and referral efforts, (6) a full accounting of payments to non-VA facilities and an evaluation of services provided therein, (7) experience under the medical confidentiality provisions in section 4132 (added by section 115(a) of the bill), (8) new program plans, and (9) any legislative recommendations.

Subsection (b) of section 204 amends the table of sections at the beginning of chapter 17 of title 38 to reflect the addition of the new subchapter which would be added by subsection (a) of this section.

Enactment of the provisions contained in title II of the Committee bill will cost \$11.51 million in fiscal year 1977.

TITLE III—MEDICAL TECHNICAL AND CONFORMING AMENDMENTS

Section 301

Provides that title III of this bill may be cited as the "Veterans Medical Technical and Conforming Amendments of 1976".

Section 302

Subsection (a) amends the title of chapter 17 by inserting the words "Nursing Home" in such title. This technical change is being made to effect a benefit which is currently available.

Subsection (b) of section 302 amends section 601(4) (defining the term "Veterans' Administration facilities") of title 38 to (1) strike out the reference to the Administrator's "exclusive" jurisdiction over VA facilities in clause (A) of paragraph (4), a reference made obsolete by the addition of section 5007 to title 38 by Public Law 93-82; much Veterans' Administration property is now within the concurrent jurisdiction of local authorities; (2) make a conforming change in clause (C) of paragraph (4) to make it clear that the Administrator may contract with private facilities only when VA or other Government facilities are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the care or services required; (3) authorize the provision of contract medical services to veterans suffering from non-service-connected disabilities, but only under two circumstances—(a) where such care is provided as part of post-hospital care under section 612(f)(1)(B), or (b) where the veteran has a service-connected disability rated at 50 percent or more and qualifies for medical services in a VA facility under section 612(f)(2) —; and (4) make conforming and organizational changes in clause (C)(i) of paragraph (4).

Subsection (c) of section 302 amends the title of subchapter II of chapter 17 by inserting the words "Nursing Home" in such title. This

technical change is being made to reflect a benefit which is currently available.

Subsection (d) of section 302 amends section 610 by inserting the words "nursing home" in the title and in subsection (a) (1) (B); deleting a reference to the "exclusive" jurisdiction of the Administrator in subsection (d); and deleting the reference to wartime service or service after January 31, 1955, in subsection (b) (2). These technical changes are made to reflect a benefit which is currently available, and changes in Federal law (made by Public Law 93-82) providing for concurrent jurisdiction over VA facilities and to conform to the more inclusive basic eligibility provided by that 1973 law for hospital care, medical services, and nursing home care under chapter 17 of title 38.

Subsection (e) of section 302 amends section 611(b) to permit the furnishing of medical services as a humanitarian service in emergency cases. The present 611(b) does provide for furnishing *hospital care* in such cases. Emergency cases requiring only outpatient care, as in the case of a deep wound requiring immediate attention without hospital admission, would be covered by this new authority. Since care obviously cannot be refused in an emergency situation, the amendment would merely provide the technical authority which was inadvertently not provided when the present emergency humanitarian treatment language was enacted. A technical correction is also made in the title of section 611.

Subsection (f) of section 302 corrects a technical error in section 612 relating to veterans of Indian Wars. Section 612 currently uses the term "Indian wars". *Clause (1)* amends this subsection to replace the lower-case "wars" with the grammatically correct upper-case "Wars". *Clause (2)* of the subsection makes a grammatical change in section 612(f) (2) (B), replacing the word "granted" with the grammatically correct word "furnished". *Clause (3)* of the subsection makes a conforming change in section 612(g) by limiting the furnishing of medical services under that subsection to the limits of VA facilities. The change is comparable to the amendment made by section 105(a) (4) of the Committee bill with respect to section 612(f) of title 38 (regarding outpatient care for non-service-connected disabilities).

Subsection (g) of section 302 substitutes the term "Office of Management and Budget" for the term "Bureau of the Budget" in section 616. The Bureau of the Budget was redesignated the Office of Management and Budget by Reorganization Plan No. 2 of 1970. This change reflects the redesignation.

Subsection (h) of section 302 amends subsection (a) of section 620 by (1) deleting references to the "exclusive" jurisdiction of the Administrator in clause (1) and the fourth sentence (a reference made obsolete by the addition of section 5007 to title 38 by Public Law 93-82 providing for concurrent jurisdiction over VA facilities), and (2) substituting the more precise word "annually" for the term "from time to time" in clause (ii).

Subsection (i) of section 302 amends the title of subchapter III of chapter 17 by inserting the words "Nursing Home" in such title. This technical change is being made to reflect a benefit which is currently available.

Subsection (j) of section 302 amends clauses (1) through (3) of section 621 to add a reference to "nursing home care". This section

currently permits the Administrator to prescribe rules and regulations governing the furnishing of hospital and domiciliary care. The addition of nursing home care merely reflects a benefit which is currently available.

Subsection (k) of section 302 amends subsection (a) of section 622 relating to an applicant's statement under oath of inability to defray necessary expenses. The reference in section 622 to "section 610(a)(1)" is changed to "section 610(a)(1)(B)", and the reference to "section 632(b)" is changed to "section 632(a)(2)". The current reference to section 601(a)(1) would, if strictly construed, require a statement of inability to defray expenses both by veterans with service-connected as well as non-service-connected disabilities. The current reference to section 632(b) relates to payments to the Republic of the Philippines rather than to the care and treatment of veterans with a non-service-connected disability. These technical changes to make the citations accurate, though necessitated by enactment of Public Law 93-82, were inadvertently omitted at that time. This amendment corrects the oversight.

Subsection (l) of section 302 amends section 624(c) (relating to hospital care, medical services, and nursing home care provided in the Veterans Memorial Hospital in the Philippines) by deleting the reference to wartime service insofar as eligibility is concerned. This change conforms to the major eligibility changes made by Public Law 93-82, as explained in the analysis of section 302(d) of the Committee bill.

Subsection (m) of section 302 amends section 627 by striking out "1958" and inserting "1957". That section is a savings provision which was intended to preserve entitlement to certain individuals who met service requirements under laws prior to the codification of title 38, but who would fail to meet those requirements on the effective date of that codification. Those laws were codified by Public Law 85-56, which carried an effective date of January 1, 1958. Therefore, the savings clause should have preserved that entitlement as of the day before the effective date, which would have been on December 31, 1957. This amendment corrects that error.

Subsection (n) of section 302 would amend subsection (a)(1) of section 628 to correct a grammatical error. Section 628 (relating to reimbursement of certain medical expenses incurred in non-VA health care facilities), added by Public Law 93-82, provides, in pertinent part "where such care and services were rendered in a medical emergency of such nature that they would have been hazardous to life or health". The word "they" should be changed to read "delay". This amendment effects the change.

Subsection (o) of section 302 amends section 641 (relating to payments to State veterans homes) of title 38 to delete the reference to wartime service. This change conforms to the basic eligibility change made by Public Law 93-82, as explained in the analysis of section 302(d) of the Committee bill.

Subsection (p) of section 302 amends section 643 to delete the reference to wartime service. This change conforms to the change made by subsection (o) of this section of the Committee bill.

Section 303

Makes technical amendments to reflect in the heading of chapters, parts, subchapters, and sections, the prior amendments authorizing nursing home care.

Section 304

Amends section 903 to authorize the Administrator to pay for transportation to the place of burial in the same or any other State of a deceased individual where death occurs in a VA nursing home care facility. Under current law, such expenses are authorized for individuals who die while receiving VA hospital or domiciliary care. Though Public Law 93-82 sought to equalize eligibility for care in VA hospitals, domiciliaries, and nursing care facilities, it inadvertently omitted the extension of this burial benefit to VA nursing home beneficiaries. This section also makes a conforming amendment in subsection (a) of section 903 to change the reference to section 611 therein to subsection (a) of that section.

Section 305

Makes a series of technical amendments in chapters 3, 39, and 73 of title 38 to locate in one place all statutory references to the medical and prosthetic research program, and for other purposes, as follows:

Clause (1) of subsection (a) of section 305 amends section 4101(a) to strike out an unnecessary first sentence (in light of section 4103, "Office of the Chief Medical Director"), define as the "primary" function of the Department of Medicine and Surgery the provision of a complete medical and hospital service, and delete the reference to medical research therein in light of the new subsection (c) which clause (3) of this subsection would add to present section 4104.

Clause (2) of subsection (a) of section 305 makes conforming changes in section 4101(b) to delete the reference to the Department of Medicine and Surgery's "primary function", made redundant by the amendment made by clause (1) of this subsection.

Clause (3) of subsection (a) of section 305 redesignates existing subsection (c) of section 4101 as subsection (d) and inserts a new subsection (c) defining and describing the Department's medical and prosthetic research program. The new subsection incorporates the existing provisions of present section 216 and portions of present section 1904, relating to the biomedical and prosthetic research program, indemnification of contractors, and development of new technologies, adds a reference to health care services and delivery research, and provides that appropriated research funds should remain available until expended.

Subsection (b) of section 305 makes the conforming changes in chapter 39 necessitated by the inclusion in chapter 73 of some of the provisions in present section 1904.

Subsection (c) of section 305 makes the conforming changes in chapter 3 (including repeal of present section 216) necessitated by the inclusion in chapter 73 of the provisions presently in section 216.

Clause (1) of subsection (d) of section 305 makes a conforming change in subsections (a) (2) and (3) of section 4103 to clarify the practice that appointment of the Deputy Chief and Associate Deputy Chief Medical Directors is made "upon recommendation of the Chief Medical Director" by the Administrator.

Clause (2) amends section 4103(a)(4) to correct a grammatical error.

Clause (3) amends section 4103(b)(3) to permit the removal for cause of employees whose appointments are extended, as well as employees appointed or reappointed.

Clause (4) amends section 4103(c) to authorize the Administrator to redesignate a member of the Chaplain Service as Director, Chaplain Service, for any period not exceeding 2 years. Redesignations are currently specified to be only for 2-year periods, as is the original designation. Clause (4) clarifies that redesignations could be made for periods of less than 2 years.

Subsection (e) of section 305 amends section 4105(a)(5) to provide that optometrists appointed to positions in the Department of Medicine and Surgery must hold the degree of doctor of optometry from an approved school of optometry. This conforms the law to the procedures currently followed by the Department, which recognizes the accreditations provided by the bodies sanctioned by the Office of Education.

Subsection (f) of section 305 amends section 4108(b) so as to make accurate the context for the reference to section 4112(b). Although an affiliation agreement is a prerequisite to the applicability of an advisory committee called for in section 4112(b), such section is not basic authority for the agreement itself; therefore, the change from "pursuant to" to "as referred to in" section 4112(b) more accurately describes the situation.

Subsection (g) of section 305 amends section 4114(b)(2) to define in more precise fashion the terms "internship" and "intern".

Section 306

Makes technical and conforming amendments to chapter 81 of title 38, as follows:

Clause (1) of subsection (a) of section 306 amends subsection (a)(2) of section 5001 to correct a grammatical error. The word "tuberculous" is substituted for the word "tuberculosis", which is erroneous in the context used in the subsection. The pertinent portion of the subsection would then read "eligible veterans who are tuberculous".

Clause (2) of subsection (a) of section 306 deletes the reference to the Administrator's "exclusive" jurisdiction over VA facilities to take account of the addition of section 5007 to title 38 by Public Law 93-82.

Subsection (b) of section 306 amends subchapter III of chapter 81 by deleting all references to wartime service in sections 5031, 5032, 5034, 5035, and 5036, for the reason described in the analysis of section 302(d) of the Committee bill.

Subsection (c) of section 306 changes the incorrect reference to "paragraphs" in the first sentence of section 5053(a) to "clauses"; and changes to "Veterans Administration health care facility" references to "Veterans Administration facility", in order to conform those references to references elsewhere in title 38.

Subsection (d) of section 306 makes a grammatical change in section 5054(b) by inserting "the" before "surrounding medical community" the second place it appears to correct the inadvertent omission of that word.

Subsection (e) of section 306 amends section 5055(a) to delete a reference to the Assistant Chief Medical Director for Research and Education in Medicine—a nonstatutory title—and substitute in its place the more proper reference to the “Assistant Chief Medical Director charged with administration of the Department of Medicine and Surgery medical research program”.

Section 307

Amends section 5083 to delete the reference to any medical school affiliated with the VA under an agreement entered into pursuant to subchapter IV of chapter 81 of this title. This would correct a technical error since subchapter IV (Sharing of Medical Facilities, Equipment, and Information) of chapter 81 does not relate to the affiliation of a medical school with the VA. As section 5083 would be amended, grants would be authorized to be made, as originally intended when this section was enacted in 1972 in Public Law 92-541, if the medical school is affiliated with the VA under an agreement entered into pursuant to title 38.

Section 308

Subsection (a) amends section 5202(b) to provide that the Administrator may dispose of the unclaimed personal property of a dependent or survivor of a veteran who dies while receiving care in a Veterans' Administration facility. Through oversight, this section was not amended at the time of passage of Public Law 93-82, which authorized such care.

Subsection (b) of section 308 amends section 5220 (a) to provide that the property of a dependent or survivor of a veteran who dies while receiving care in a Veterans' Administration health care facility shall vest in the United States if the deceased leaves no surviving heirs. Through oversight, this section was not amended at the time of passage of Public Law 93-82, which authorized such care.

Subsection (c) of section 308 amends section 5221 to provide that the fact of death of a dependent or survivor of a veteran who dies while receiving care in a Veterans' Administration health care facility and leaves no surviving heirs shall give rise to a conclusive presumption of a valid contract for the disposition of all property left by the decedent. Through oversight, this section was not amended at the time of passage of Public Law 93-82, which authorized such care.

Section 309

Amends chapter 73 of title 38 for three purposes: (1) To change all references to “physician’s assistants” and “physicians’ assistants” to a standardized reference to “physician assistants”, and to change all references to “dentists’ assistants” and “expanded-duty dental auxiliaries” to “expanded-function dental auxiliaries”; (2) to change all references to “pay”, “compensation”, and “wages” to a standardized reference to “rate of basic pay”; and (3) to change references to “individuals” and “employees” to a standard reference to “persons” and “personnel”.

Section 310

Amends chapters 17, 73, 81, and 82 to eliminate all nouns and pronouns which discriminate on the basis of gender, and substitute non-

discriminatory references to "the Administrator", "the Chief Medical Director", "the veteran", other nouns, and the possessive adjectival forms of such nouns where appropriate.

Section 311

Establishes October 1, 1976, as the effective date for all amendments made by the Committee bill (except as otherwise provided in the Committee bill). Specific other effective dates are provided in section 110(c) of the Committee bill (January 1, 1977 regarding the provision of services—planning may begin immediately—in the preventive health care program), new section 662(b)(1), as added by section 110(a) of the Committee bill (October 1, 1977, regarding the initiation of the health maintenance preventive health care pilot program), and section 112(b) of the Committee bill (upon, or 180 days after, the enactment date, regarding shortening the probationary period for title 38 employees).

TABULATION OF VOTES CAST IN COMMITTEE

Pursuant to section 133(b) of the Legislative Reorganization Act of 1946, as amended, the following is a tabulation of votes cast in person or by proxy of the Members of the Committee on Veterans' Affairs on a motion to report S. 2908, with an amendment, favorably to the Senate:

Yeas—9

Vance Hartke
Herman E. Talmadge
Jennings Randolph
Alan Cranston
Richard (Dick) Stone
John A. Durkin

Clifford P. Hansen
Strom Thurmond
Robert T. Stafford

Nays—0

AGENCY REPORTS

The Committee requested and received reports from the Veterans' Administration and the Office of Management and Budget, on medical related bills pending before the Committee. These reports and other pertinent material follow:

[No. 131]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE,
Washington, D.C., August 17, 1976.

HON. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs, U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to S. 2908, 94th Congress, a bill to amend title 38, United States Code, to improve the quality of hospital care, medical services, and nursing home care in Veterans' Administration health care facilities; to require the availability of comprehensive treatment and rehabilitative services and programs for certain disabled veterans suffering from alcoholism, drug dependence, or alcohol or drug abuse disabilities; to make certain technical and conforming amendments; and for other purposes.

The purpose of this bill is as stated above. The majority of the provisions of this bill pertain to the Veterans' Administration. Section 204 of this bill impacts directly on the Department of Defense. Section 204 would add, *inter alia*, section 666 to chapter 17 of title 38, United States Code, establishing procedures which would permit the transfer, and treatment therein, of active duty servicemen to Veterans' Administration facilities in connection with drug abuse.

The Department of Defense is opposed to the provisions of section 666 which section 204 of the bill would add to chapter 17 of title 38, United States Code. The Department of Defense policy is to provide treatment for drug abusers in military facilities when they can be rehabilitated in a short period of time, have further service potential and have time remaining in the service. All others are referred to civilian programs or are phased into Veterans' Administration programs. Individuals who are determined to be drug dependent at time of separation are transferred to a Veterans' Administration hospital 15 days prior to date of discharge via the Armed Services Medical Regulating Office. In the event it is desired to transfer drug dependent active duty members of the military to Veterans' Administration facilities as allowed by section 666, subsection (c) of that section would prohibit the transfer unless the member requests the transfer in writing for a specified period of time within the member's tour of duty. The requirements of subsection (c) would conflict with the procedures presently followed for transfer of members to Veterans' Administration facilities and would severely limit the program now in effect.

The transfer of individuals to the Veterans' Administration is being accomplished with minimum administrative problems and the continuity of treatment received by the servicemember is effectively maintained. Consequently, a change to the current policy which would in effect permit the drug dependent servicemember to decide whether or not he is to be transferred to a Veterans' Administration hospital, and for how long, is considered unwise.

Subject to the foregoing comment, the Department of Defense defers to the Veterans' Administration on the merits of the other provisions of S. 2908.

Your continuing interest and concern to improve the quality of medical care for veterans is greatly appreciated.

The Office of Management and Budget advises that, from the standpoint of the Administration's program, there is no objection to the presentation of this report for the Committee's consideration and recommends against enactment of S. 2908 unless modified as recommended by the Veterans' Administration.

Sincerely,

RICHARD A. WILEY.

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., March 2, 1976.

HON. VANCE HARTKE,
*Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 2908, 94th Congress, a bill "To amend title 38, United States Code, to improve the quality of hospital care, medical services, and nursing home care in Veterans' Administration health care facilities; to require the availability of comprehensive treatment and rehabilitative services and programs for certain disabled veterans suffering from alcoholism, drug dependence, or alcohol or drug abuse disabilities; to make certain technical and conforming amendments; and for other purposes."

S. 2908 contains a number of provisions directed toward extending or clarifying the authority of the Department of Medicine and Surgery to provide care to veterans. There are other provisions which would facilitate the administration of this program. There are still other provisions which would redirect the emphasis of veterans medical care to the service connected veteran. A complete analysis of each of these provisions is enclosed herewith, as well as our position thereon and a cost analysis thereof.

As can be ascertained by reading the enclosed analysis, there are a number of provisions of this bill which we favor. Furthermore, there are other provisions which may have some desirable features, but which provide the type of benefit extensions with associated cost factors which we cannot support, particularly at this time when the need for reasonable restraint in the growth of Government spending is being stressed. In this regard, we share the concern expressed by Senator Cranston at the time this measure was introduced. As the Senator suggested, we must question whether it is reasonable for the VA health care budget to continue to expand at the rapid rate achieved over the last 5 years, and whether the VA can continue to provide more and more care and services to more and more veterans and still be able to make the treatment of veterans service connected disabilities our primary focus. Accordingly, for the reasons specified in the analysis, we cannot support the bill as introduced.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely,

ODELL W. VAUGHN,
Deputy Administrator,
(In the absence of
Richard L. Roudebush, Administrator).

Enclosure.

SECTION-BY-SECTION ANALYSIS OF S. 2908, 94TH CONGRESS

The first section of the bill provides that the Act may be cited as the "Veterans Omnibus Health Care Act of 1976".

TITLE I—GENERAL VETERANS HEALTH CARE AND DEPARTMENT OF MEDICINE AND SURGERY AMENDMENTS

Section 101 would amend section 111 of title 38 by adding a new subsection (e).

Subsection (e), paragraph (1) directs the Administrator, in consultation with the Administrator of General Services, the Secretary of Transportation, the Comptroller General of the United States, and representatives of organizations of veterans, to conduct periodic investigations of the actual cost of travel, including lodging and subsistence, to beneficiaries while traveling to or from a VA facility or other place, and the estimated cost of alternative modes of travel, including public transportation and the operation of privately owned vehicles. The Administrator would be required to conduct these investigations at least annually and determine the rates of allowances or reimbursement to be paid, but in no event would such rates provide for reimbursement of privately owned vehicle costs unless public transportation is not reasonably accessible or would be medically inadvisable, except with respect to a veteran who is receiving hospital care or medical services for a service-connected disability nor would reimbursement exceed the actual expense incurred as certified by the veteran. Factors to be considered in such investigations would include depreciation of original vehicle costs; gasoline and oil costs; maintenance, accessories, parts, and tires; insurance; State and Federal taxes; availability of public transportation; and the expenses of Federal employee travel.

Paragraph (2)—Before determining rates of allowances or reimbursement the Administrator is required to (A) submit to the Committees on Veterans' Affairs of the Senate and House, a report containing the proposed rates with a justification therefor; and (B) proceed with a notice of proposed rulemaking in accordance with section 553(d) of title 5, including publication in the Federal Register, together with full justification.

Under current law (section 111(a) of title 38), a VA beneficiary who travels in connection with Veterans' Administration vocational rehabilitation, counseling, or for the purpose of examination, treatment, or care, may pay his own necessary expenses of travel by personally owned conveyance and be reimbursed on a mileage basis; he may pay his own expenses of travel and be repaid for actual and necessary expenses; or he may obtain a Government Transportation Request from the VA for presentation to the ticket office in exchange for his bus or train ticket. The veteran may also obtain from the VA reimbursement for any necessary expenses for meals and lodging. The authority of the President, pursuant to section 111(a) of title 38, to set rates for travel of certain VA beneficiaries, was delegated to the Administrator of Veterans' Affairs by Executive Order 11609, dated

July 22, 1971. Currently, the allowance may be fixed by the Administrator in such amount per mile as he determines.

We periodically make studies to determine the adequacy of beneficiary travel allowances. Such a study is underway now, in accord with the Administrator's directive to completely reevaluate our policy with respect to beneficiary travel. This study is considering the factors proposed in this bill. Upon completion of this study we will be considering a revision of our current mileage and per diem rates.

We are aware that higher than necessary costs may be incurred when a person chooses to use other than common carrier transportation. We therefore favor the concept of limiting reimbursement to the cost of common carrier. However, we do recognize that situations exist where commercial transportation is not available or where the veteran beneficiary may have a physically disabling condition which would make it unwise, if not extremely difficult, to use such public transportation. In these excepted instances, particularly with service-connected veterans, we favor reimbursement for necessary private travel expenses beyond common carrier.

We believe the reevaluation of our rate setting procedures, which is now underway, demonstrates the desirability of having the type of general authority now contained in 38 U.S.C. 111, which can be used to make rapid administrative change when the need is presented.

We also believe it demonstrates that the Administrator now has sufficient authority to accomplish the basic purpose sought to be achieved by the subject bill. Furthermore, we do not believe that a replacement of the current flexible authority with a set of specific guidelines, such as would be provided by section 101, would be desirable. Moreover, we object strenuously to that portion of the bill which would require a notice of proposed rulemaking under section 553 of title 5, since we do not think the rulemaking procedure is applicable to a situation where you have specific factors required by statutes which must be considered.

We are unable to estimate with any specificity, the cost of implementing section 101, since the cost would depend on the result of an investigation into the costs of beneficiary travel using the factors required by the bill. It is anticipated, however, that the consideration of the additional factors would result in an increase in the mileage allowance now authorized for private vehicle travel. On the other hand, some of this increase in costs might be offset by the savings which would result from the limitation imposed in the bill as to when privately owned vehicle travel costs can be reimbursed, and we look with favor on such a limitation if this provision is to be enacted. However, we do not favor this section as a whole.

Section 102 of the bill would amend section 601 of title 38, U.S.C., which section contains the definitions specifically applicable to chapter 17 benefits.

Clause (1) would redesignate paragraphs (2) through (7) as paragraphs (3) through (8), and would insert a new paragraph (2). The new (2) would define "veteran" so as to permit the furnishing of hospital care and medical services for a service-connected disability to a person, not otherwise barred by the provisions of 38 U.S.C. 3103,

who has a discharge or release which is "other than a dishonorable discharge."

Under the present general definition of veteran contained in 38 U.S.C. 101(2), which is applicable to the chapter 17 benefits, the person must have a discharge or release which is "under conditions other than dishonorable." The change in language would effect a liberalization in that all persons with "other than honorable" or "bad conduct" discharges (other than those resulting from general courts-martial) would automatically be eligible for treatment for a service-connected disability. The present eligibility criteria with respect to the nature of the individual's discharge was based upon the premise that the obligation of the nation should not extend to those who did not serve it honorably. We see no justification for changing this basic premise at this time. Furthermore, this would lead to an unwise fragmentation of eligibility for veterans benefits in that a person would be a "veteran" for one benefit (medical care) but not another (such as compensation, education, etc.). This will not only lead to confusion, but it will lead to demands that the new criteria be equally applicable to all other benefits. Accordingly, we oppose this provision.

Clause (2) makes changes in the definition of "hospital care." as redesignated paragraph (6). Subclause (A) adds "rehabilitative services," which is subsequently defined in clause (5), to the definition of "hospital care." Since "rehabilitative services" are included by definition as a part of "medical services" and medical services are specifically included in the definition of hospital care, it is not clear why rehabilitative services should also be separately stated to be a part of hospital care. In any event, we now provide those rehabilitative services that are considered essential to, and a part of, the basic medical care being furnished the veteran; and we, therefore, see no need to make the proposed change.

Subclauses (B) and (C) would accomplish the removal of (B) from paragraph (6) and the redesignation of (C) as (B). The deleted (B), the essence of which is added to the definition of "medical services" by subclause (3), *infra*, relates to the provision of mental health services for the family of an ill veteran.

Clause (3) amends the redesignated paragraph (7) so that the definition of "medical services"—

- (a) includes "rehabilitative services";
- (b) specifically mentions podiatrists' services, even though they have long been considered to be authorized by our present authority;
- (c) specifically mentions certain drug control measures;
- (d) authorizes minor home improvements and structural alterations necessary to provide access to the home or to essential lavatory or sanitary facilities or to assure the continuation of treatment of veterans receiving treatment on a post-hospital care basis, or for a veteran with a service-connected disability rated at 50 percent or more; and
- (e) includes the provision of mental health services for the family, formerly contained as part of hospital care.

While we favor some extension of authority to allow outpatient counseling of the family of certain veterans when that counseling is of limited duration and directly related to the effective treatment of the veteran, we cannot endorse the broad program of mental health services which this proposal would authorize, particularly as it would relate to the family of veterans suffering from non-service-connected conditions. Moreover, we feel the language proposed is entirely too broad. Because any mental problems affecting a family member can be interpreted as affecting the veterans "effective treatment and rehabilitation" the bill could be construed to authorize a general outpatient mental health program for the 62.6 million living family members of veterans and an unknown number of legal guardians and certain household companions.

While we cannot recommend the broad proposal contained in this bill, we would recommend an amendment which would authorize a limited program of counseling to the immediate members of the family of a service-connected veteran, tied directly to the veteran's effective treatment, with family problems and problems of individual family members identified in the course of this counseling referred to other mental health programs in the community. In other words, the proposal would not include the full spectrum of therapeutic intervention, and would not include chemotherapy or aggressive psychotherapeutic approaches directed to inherent psychopathology of the family members.

Furthermore, counseling should be directed only to those components of patient/family interaction which reinforce the service-connected veteran's pathology or limit the effectiveness of active treatment directed toward a disease process. It should also be provided to only those immediate family members, legal or surrogate, with whom the veteran resides or who are in such a close personal relationship that there is a reason to believe the relationship influences success of the veteran patient's care.

Although it is difficult to cost an open-end proposal such as is contained in the bill, our preliminary calculations indicating that the 5-year cost would total well over \$0.5 billion as follows:

Fiscal year:		Cost
Transition quarter	-----	\$23, 640, 000
1977	-----	112, 245, 000
1978	-----	118, 205, 000
1979	-----	118, 205, 000
1980	-----	118, 205, 000
1981	-----	118, 205, 000

If amended as we have proposed, and limited to the counseling directed towards a veteran's service-connected condition, the cost would be much more limited, although we have not been able to cost such proposal with any specificity.

We do not favor the inclusion of authority to make structural improvements to private property under the guise of medical care. There is now statutory authority for adaptive housing for the seriously handicapped contained in chapter 21 of title 38. We feel this is sufficient. While there has been an enlargement in the concept of the term medical care in the country as a whole, we are unaware of any

concept of that term which would encompass home structural improvements.

Clause (4) amends the definition of "domiciliary care" to include the necessary medical services and rehabilitative services.

A member of any VA domiciliary is presently entitled to all necessary medical services including hospitalization if needed. Since medical services includes the provision of rehabilitative services, the proposed amendment to the definition of "domiciliary care" would not authorize additional services and would not increase costs.

Clause (5) adds a new paragraph (9) to define the term "rehabilitative services" as being those professional services (including vocational guidance) or treatment programs necessary to restore the physical, mental, and psychological functioning of an ill or disabled person. The type of vocational rehabilitation services authorized under chapter 31 are not included. These rehabilitative services may be made available as a form of hospital, nursing home, or domiciliary care, and on an outpatient basis.

While rehabilitation services are now considered to be an important part of medical care, we believe there should be a clear line of demarcation between medical care and vocational rehabilitation. For this reason, we believe the references to vocational guidance contained in this new definition should be deleted. Moreover, there is specific statutory authority contained in chapter 31 for vocation rehabilitation, and eligibility therefor along with vocational guidance, should be limited to the class of veterans eligible under that chapter.

The major cost items contained in the above definition change relate to (1) home structural modifications which are expected to be \$100,000 for the transitional quarter, \$650,000 for fiscal year 1977, \$2,250,000 for fiscal year 1978, \$1,875,000 for fiscal year 1979, \$1,500,000 for fiscal year 1980, and \$1,125,000 for fiscal year 1981; (2) the requirement that vocational guidance be provided as part of rehabilitative services—transitional quarter \$197,000, fiscal year 1977—\$394,000, fiscal year 1978—\$1,182,000, fiscal year 1979—\$986,000, fiscal year 1980—\$789,000 and fiscal year 1981—\$394,000; (3) character of discharge change for treatment of service-connected disability—\$250,000 annually; and (4) the provision of family mental health services on an outpatient basis which is estimated to cost \$23,640,000 for the transitional quarter, \$94,565,000 for fiscal year 1977, \$118,205,000 for fiscal year 1978, \$118,205,000 for fiscal year 1979, \$118,205,000 for fiscal year 1980, and \$118,205,000 for fiscal year 1981.

Section 103 of the bill will liberalize the presumption relating to psychosis found in 38 U.S.C. 602. Currently, for purposes of chapter 17 only, any veteran of World War II, the Korean conflict, or the Vietnam era who developed an active psychosis within 2 years after discharge or release, or before prescribed dates for each of the periods mentioned, shall be deemed to have incurred such disability in active service. This bill would remove the requirement that it be an active psychosis, thereby making a veteran with the necessary service eligible for chapter 17 benefits of any psychosis is developed within 2 years, regardless of whether such psychosis is active.

We do not believe that this provision can be justified. Presumption of service connection has always been constructed as medically un-

sound since it tends to deem a disability as having been incurred as a result of service, contrary to factual evidence.

Furthermore, the elimination of the requirement applicable to the existing presumption that it be an "active" psychosis, adds a further element of confusion which makes it even more difficult for a medical judgment to be made as to whether a disability really exists. It is felt that removal of the word "active" before psychosis in the bill would result in patients who have complete remission and have had such remissions for long periods of time, becoming eligible for treatment in the VA hospital.

We do not favor section 103 of the bill.

It is anticipated that there would be some additional costs associated with the enactment of this provision, but we do have sufficient data at this time to allow us to estimate such cost increase.

Paragraph (a) of section 104 introduces a new section into title 38, section 603. This section will provide, for chapter 17 purposes only, that the disability of a veteran who was a prisoner of war for more than 6 months, shall be deemed to have been incurred in the active service, provided sound medical judgment determines the disability could be attributable to, or aggravated by such internment, unless the Administrator finds such claim without merit, based on clear and convincing evidence.

Paragraph (b) of section 104 makes the necessary technical additions to title 38 to reflect the new section.

Veterans' Administration regulations emphasizing the liberality which is accorded in prisoner of war cases include, for example, a provision that the development of symptomatic manifestations of a preexisting injury or disease during or closely following a status of a prisoner of war will establish aggravation. Physical examinations of former prisoners of war are conducted with particular thoroughness to discover, if possible, all disabilities common to prisoners of war even where there has been no complaint or prior evidence of such condition. Existing instructions provide that in the evaluation of disabilities resulting from or incident to military service, great weight must be assigned to imprisonment or internment under unsanitary conditions or to food deprivation in the service connection of dysentery and other gastrointestinal diseases. All of these considerations permit the VA to reach an equitable decision on the basis of the facts of each individual case, with any reasonable doubt being resolved in favor of the former prisoner of war.

The Veterans' Administration believes that special consideration should be given to former prisoners of war and strives to assure that they receive all benefits in full measure under the law. However, there seems little justification for giving preference solely on this basis when many who underwent comparable privations and hardships, as for example in extended combat, would not be afforded similar consideration. Furthermore, such treatment would further fragment eligibility for veterans' benefits in that former prisoner of war veterans would be service-connected for some benefits and not for others.

As a technical matter, we would like to point out that the last clause of the proposed new section which reads "unless the Administrator finds such claim without merit based upon clear and con-

vincing evidence" is unnecessary, and actually inconsistent with the earlier phrase "on the basis of sound medical judgment". If the "sound medical judgment" indicates that service-connection is warranted, there could be no "clear and convincing evidence" to the contrary.

Therefore we do not favor this provision.

Section 105 of the bill makes a number of changes in section 12 of title 38. Clause (1) amends subsection (a) to clarify the authority of the Administrator to furnish to veterans for their service-connected disability, such home health services as are found to be necessary or appropriate for the effective and economical treatment of such disability, including the home improvements and structural alterations referred to in the revised definition of medical services found in section 601(7)(B) of this title, as modified by section 102(3) of this bill. We have been making home health services available for the treatment of service-connected disabilities on the assumption that these service-connected veterans are eligible to receive such services, as non-service-connected veterans are treated under 38 U.S.C. 612(f). We will acknowledge, however, that there could be some question raised as to whether the service-connected veterans' home can be considered a VA facility as defined in 38 U.S.C. 601(4). Since section 612(b) of title 38 limits care to this class of individual to that which can be provided in "VA facilities," we believe the proposed clarification is desirable.

We do not agree for the reasons specified earlier, with the inclusion of structural home modification as a part of medical care. Moreover, the absence of the word "minor" which is contained in the earlier referred to provision, could lead to demands for major home renovation under the chapter 17 medical care authority, in addition to the special adaptive housing grant available under chapter 21. It is anticipated that the present renovation proposal will cost \$63,000 for the transitional quarter; \$187,000 for fiscal year 1977; \$750,000 for fiscal year 1978; \$625,000 for fiscal year 1979; \$500,000 for fiscal year 1980; and \$375,000 for fiscal year 1981. Clauses (2) and (3) purport to liberalize provisions of 38 U.S.C. 612(b) dealing with furnishing of outpatient dental services and treatment, and related dental appliances.

Clause (2) has caused us some trouble in interpretation in that it seems to authorize an expanded authority to provide dental care for a condition which is associated with or aggravating medical disability for which the veteran is receiving treatment, yet it specifically provides that such care and treatment should not encompass routine dental care. Therefore, it would appear that it would actually provide very little, if any, authority beyond that which would be provided under the new clause (5), spelled out in clause (3) of this section. Accordingly, we would suggest that this amendment be deleted to avoid confusion.

Clause (3) redesignates clause (5) of subsection (b) clause (6) and introduces a new clause (5). The new clause (5) authorizes outpatient dental care and treatment for a non-service-connected condition or disability of a veteran for which (A) treatment was begun during a period of hospitalization, or (B) where such dental care and treat-

ment is reasonably necessary to relieve pain or control infection, or both, and only to that extent. We favor the proposal contained in subclause (A) with some modification, but not that contained in subclause (B).

We have encountered some problems in completing the dental needs of hospitalized veterans during the time of their hospital stay for the medical condition being treated and, have found it necessary to continue hospitalization of some veterans who could otherwise be released earlier in order to complete the dental program started in the hospital. For example, there are occasions where veterans have had their teeth pulled and are fitted for dentures or dental appliances which require several days to fabricate. If we could discharge the veteran, but have authority to call him back on an outpatient basis to give him the dentures or appliances already fitted, we believe a cost savings would result, since it would avoid keeping him in the hospital for an additional period of time. We would support this clause if the language was amended to limit its application to the type of situation discussed above.

On the other hand, the proposal contained in subclause (B) would be a major cost item which could be difficult to control. Furthermore, it would be an extension of outpatient dental care, even though on a limited basis, to non-service-connected veterans which we feel is not justified at this time, in light of the need to focus on service-connected care.

While we do not favor all of the amendments relating to outpatient dental services, if they are to be considered further by the Committee, we would point out that the term "major restoration" as used in the new clause (5) has no point of reference in dental terminology and could be easily misinterpreted. Instead, it is suggested that the term "permanent restoration" be used, which would restrict this type of care to temporary or sedative type restoration. Moreover, we also suggest that the words "other definitive" be inserted before the word "therapy." This would preclude the demand for such treatment as extension periodontal therapy, root canal fillings, etc.

We are unable to estimate the cost of subclause (B) of this proposal. However, assuming that the authority provided in the amendment to clause (4) of section 612, as provided by clause (2) of this section, contains no new authority beyond that which would otherwise be authorized by the new clause (5) of such section 612(b), the estimated cost of this proposal is as follows:

Transition quarter-----	\$1, 250, 000
1st year-----	5, 000, 000
2d year-----	5, 000, 000
3d year-----	5, 000, 000
4th year-----	5, 000, 000
5th year-----	5, 000, 000

If we were able to discharge a patient sooner than we normally would due to the fact that we could take care of his dental needs on an outpatient basis, there would be a savings factor to consider, and the actual increased cost would be less than that indicated above.

Clause (4) limits the provision of medical services under subsection (f) to those which can be provided "within the limits of VA facilities."

Currently, subsection (f) benefits are not so limited. This amendment is consistent with the basic premise that VA medical care is intended primarily for the service-connected veterans, with the non-service-connected to be provided care only to the extent that facilities not being utilized for the service-connected are available. It should be noted that the effect of this change is somewhat minimized by the redefinition of "VA facilities" contained in title III of the bill, which would broaden the authority of the Administrator to contract on a fee-basis for private care when VA or governmental facilities are not geographically accessible, or are not capable of furnishing the care or services required. Additional comments on this proposal are contained in other parts of this analysis.

Clause (5) would limit the availability of medical services on an outpatient or ambulatory basis where such will obviate the need of hospital admission. Such services could be provided only "(to the extent that facilities are available)."

This, in effect, provides some additional priority in the type of care or class of beneficiaries which can be treated, making the "obviate" type care dependent upon facilities being available, and requiring that the pre-hospital care and post-hospital care needs of patients be taken care of first. The last priority in the provision of outpatient non-service-connected care will thus be given to those who need care to avoid or "obviate" hospital admission, and there would be no authority to contract for private non-VA care for this category of individual.

Clause (6) would amend section 612(f)(1)(B) to provide that post-hospital care reasonably necessary to complete treatment incident to such hospitalization will be limited to 12 months, unless the Administrator determines (1) that a longer period is required for the disability, and (2) with respect to private facilities contracted for by VA, an alternative Federal reimbursement (such as Medicare) is not reasonably available to defray substantially the costs of such treatment. Currently, there is no limit in the law to the period of time for which post-hospital treatment can be given, although administratively a medical determination must be made of continuing need. While there is sufficient authority to provide additional care where the disability of the veteran demands it, we can envision some problems with the requirement that the needed extended service cannot be provided if alternative Federal reimbursement is available, unless some additional authority is provided to assist the veteran who is otherwise unable to meet any deductible or coinsurance requirement that might be applicable to the other Federal program.

Clause (7) amends section 612(f)(2) of title 38 to authorize the Administrator to provide medical services for any condition to any veteran who has a service-connected disability rated 50 percent or more. Currently, this benefit is available to a veterans whose service-connected disability is rated at 80 percent or more.

We are not in favor of the portion of section 105 of the bill which would change the authority for ambulatory care for any condition from veterans with a service-connected disability of 80 percent or more to those with 50 percent or more service-connected disability. Generally, veterans with a service-connected disability of this severity are markedly impaired in earning capacity, and the non-service-con-

nected illnesses aggravate this condition. Although it is difficult to establish a breaking point in terms of percentage of disability where the provision of outpatient medical services for any disability can be justified, we believe that the 80 percent point now established is reasonable and equitable. We now have authority to treat non-service-connected conditions judged to be adjunct to a service-connected disability regardless of the percentage of a disability rating. In our opinion, this authority meets the essential needs of veterans with service-connected disabilities rated less than 80 percent.

We believe that limiting post-hospital care to 1 year would not result in any significant savings since most of those currently exceeding 1 year would continue to be included on the basis of their disability. Lowering the per centum rate from 80 percent to 50 percent for outpatient treatment of non-service-connected conditions would increase workloads and costs with respect to this category of veterans.

We estimate that the increase in costs to the VA for each of the first 5 years following enactment would be as follows if we treated those veterans now eligible as well as the new group of eligibles:

Fiscal year:		Cost
Transition	quarter	\$7,981,000
1977		31,926,000
1978		33,150,000
1979		34,373,000
1980		35,041,000
1981		35,708,000

Clause (8) inserts a new subsection in the law, 612(i), which would require the Administrator to establish by regulations issued within 90 days of the enactment of this subsection a priority system for the furnishing of medical services under subsection (f). Except in medical emergencies which pose a serious threat to life or health, priority shall be given to a veteran—

- (1) for his service-connected condition;
- (2) who has a service-connected disability rated at least 50 percent;
- (3) who has a service-connected disability; or
- (4) who is eligible for 612(g) benefits by reason of need for aid and attendance or being permanently housebound.

Paragraph (b) of section 105 of the bill requires the Administrator to annually report to the Congress the results of the priority regulations adopted to complement section 612(i). We have no objection to the proposed priority system for furnishing medical services, although as indicated earlier, we do not favor the extension of the total care authorized by 38 U.S.C. 612(f) (2) to the 50 percent disabled veteran. Furthermore, we feel the required annual report to the Congress is unnecessary and would add little knowledge about the program since the whole priority system is premised upon the assumption that the serious medical problems will be treated first, with the remaining eligibles included in the system in the order of their priority.

Section 106(a) of the bill would insert a new section into the law, 38 U.S.C. 612A, which would authorize VA to furnish readjustment professional counseling and to make a general physical, mental, and psychological assessment in connection therewith to new veterans during a period not to exceed 4 years following discharge or release

from service, or 2 years following the enactment of this legislation, whichever is later. (We understand that an amendment has been offered limiting these services to those which can be provided within the VA). Hospital care and medical services needed as a result of the assessment shall be provided in accordance with the eligibility criteria for chapter 17 benefits, and the VA shall provide referral services where indicated. This provision would assist the veteran through a readjustment process upon return to civil life, without a necessity for a diagnosis of illness as is now necessary before any professional assistance may be provided, and without tying it into a hospitalization episode.

This provision would give a preferential treatment to the Vietnam era veteran, which is not available to veterans of other periods of service. Furthermore, there has been a sufficient period of time since the Armed Forces conflict in Vietnam to allow most returning servicemen to successfully adjust to their return to civilian life. Moreover, those who have not yet adjusted would appear to have a psychological problem of such intensity as to require that they receive the type of indepth care and treatment now authorized by chapter 17 of title 38 for all veterans with psychological disabilities. In this regard, it is reasonable to assume that many individuals in this class are now being cared for by the VA. Accordingly, we see no need for this new liberalized provision applicable solely to the Vietnam veteran and do not favor its enactment.

Our cost estimate for this section of the bill is as follows:

Transitional quarter-----	\$14, 566, 000
1st year-----	58, 265, 000
2d year-----	5, 138, 000
3d year-----	5, 138, 000
4th year-----	5, 138, 000
5th year-----	5, 138, 000

Section 107 of the bill amends 38 U.S.C. 613(a) (2) to extend medical benefits to the survivors of any veteran, who, at the time of death, was suffering from a permanent disability resulting from a service-connected disability.

Section 613(a), as currently worded, provides medical care for the wife or child of any veteran who has a total disability, permanent in nature, resulting from a service-connected disability. It also provides medical care for the widow or child of any veteran who died as a result of a service-connected disability. This means that the wife or child who may be currently eligible for medical care by reason of the veteran having a total disability, permanent in nature, resulting from a service-connected disability, loses that entitlement in the event the veteran dies of a non-service-connected cause.

We favor this proposed because it follows a longstanding and justifiable practice of recognizing that a veteran who has a service-connected total disability is in a special category and deserving of assistance for the sacrifices he and his family have made. It would provide for the widow or child of a veteran who died as a result of a non-service-connected cause, while a total and permanent service-connected disability was in existence, to continue to receive an adequate level of medical care without the need and inconvenience of arranging for another source of care and possibly with some lessen-

ing of the scope and/or effectiveness of the care received. This amendment would bring the treatment of such widow and child under the CHAMPVA program in line with that applicable to the survivors of a former serviceman under the CHAMPUS program, upon which it was based.

Enactment of the subject bill would result in an estimated annual cost to the Veterans' Administration of \$56,984.

Section 108 of the bill would amend section 618 of title 38, U.S.C., by making the current provision of law subsection (a), striking the word "the" and inserting in lieu thereof: "In providing rehabilitative services under this chapter, the." In addition the term "health care facilities" would be substituted for the terms "hospitals and domiciliaries."

New subsection (b)(1), which would be added to section 618, authorizes the Administrator, in providing rehabilitative services, upon the recommendation of the Chief Medical Director, to enter into arrangements with private industry or other sources to provide therapeutic work for pay for patients and members of VA medical facilities.

New subsection (b)(2) would authorize the Administrator to provide rehabilitative services under this section through arrangements with nonprofit entities. This subsection requires the Administrator to establish various controls over such nonprofit entities in connection with such arrangements when such nonprofit entities are utilized. These controls would include fiscal accounting, management, record-keeping, and reporting.

Paragraph (1) of new subsection (c) would establish in the United States Treasury a fund known as the Veterans' Administration Special Therapeutic and Rehabilitation Activities Fund for carrying out the provisions of subsection (b) of section 618. This paragraph would authorize the Administrator to deposit funds for use in the various rehabilitative service in checking accounts selected or established by the Administrator.

Paragraph (2) provides that all funds received by the VA through arrangements made under subsection (b) of this section would be deposited in the fund and the Administrator would, from that fund, pay all participants at such rates prescribed in regulations the Administrator is required to issue. These regulations must be in accordance with applicable law and regulations. In no event will participants be paid at rates less than those prescribed in applicable portions of the Fair Labor Standards Act.

Paragraph (3) authorizes the Administrator to use funds which have accumulated in the NSLI Fund to initiate and maintain the program authorized in subsection (b) of this section. The NSLI Funds so used will be considered a loan and will earn interest.

Paragraph (4) requires the Chief Medical Director to prepare a report of activities carried on under this section. This report will be included in the annual report submitted to Congress under section 214 of this title. This paragraph also requires that any balance in the fund at the end of the fiscal year be covered into the Treasury to pay accrued interest and principal on any NSLI fund obligations.

Subsection (d) provides the Administrator shall take appropriate action to make it possible for patients to take maximum advantage of any benefits to which such patient is entitled under chapter 31, 34, or 35 of title 38, U.S.C. This section would authorize coordinating the rehabilitative services with the pursuit of education and training of patients receiving treatment of a prolonged nature.

Subsection (e) directs the Administrator to prescribe regulations to ensure that the priorities set forth in section 612(i), insofar as possible, be applied for participation in the therapeutic and rehabilitative activities carried out under this section.

Section 108(b) (1) of the bill would authorize the Administrator to settle any claims the VA might have against private nonprofit corporations for the use of VA facilities and personnel in therapeutic work projects for patients conducted by such corporation. The section also authorizes the Administrator to execute a binding release of such claims.

Subsection (b) (2) of section 108 of the bill authorizes the Administrator to utilize any funds received under any settlement authorized by subsection (b) (1) of this section, for any purpose agreed upon by the Administrator and such corporation.

The value of compensated work programs as a therapeutic modality is widely acknowledged. They provide therapeutic (psychosocial and/or physical) rehabilitation of the participant. Participation induces motivation, heightens self-esteem and breaks institutional patterns through the use of remunerative work with the expectation of either increasing the participant's potential for adjustment to the community, or preventing regression from present functional level. It reinforces through the use of well-established motivational principles ("rewards"), modifications or development of attitudes, habits, skills, and behaviors necessary to attain or maintain a maximum level of social and psychological adjustment.

Compensated Work Therapy provides a realistic everyday-life working environment conducive to the development of work tolerance and effective learning of work habits and skills.

These programs have been utilized within the Veterans' Administration for many years, and the proposed amendment to section 618 of title 38 would merely provide a specific statutory reference to the program. It would also clarify our authority to obtain the needed work projects through contractual arrangements with private industry. We strongly support these two objectives. We do not, however, favor that portion of the proposed new language which would establish a revolving fund to handle the fiscal aspects of the program, for several reasons.

First, we believe that before a new revolving fund is established, which admittedly is an exception to normal fiscal procedures, we should assure ourselves that there are not other approaches which could be used to meet the needs of the program. For example, it would appear that once our authority to procure the needed work projects from private industry is clear, normal Government procurement procedures might be workable. Furthermore, while we recognize that a means must be found to handle the funds which will flow from private industry to the patients participating in the program, it may be that a better approach would be to set up a special trust fund in

the Treasury to handle such funds, or to allow the General Post Fund, which has already been so established, to be utilized for this purpose. In any event, we believe further study is needed before a particular approach is decided upon, and therefore think establishment of a revolving fund is inappropriate at this time.

There are, of course, other reasons why the proposed approach to handling the fiscal aspects of the program cannot be supported, particularly the proposal to use NSLI trust funds to provide necessary start up money.

In considering the use of the National Service Life Insurance Fund for any purpose, it must be emphasized that the fund does not belong to the Administrator, the VA, or the United States Government. The fund belongs to the more than 4 million policyholders of National Service Life Insurance.

The Administrator, as head of the VA, is the trustee of the fund and, as trustee, has the solemn, if not the sacred obligation to protect it and insure its integrity. The subject bill would provide for the transfer by the Administrator of that portion of the National Service Life Insurance which, in his discretion, should be used to create a revolving fund known as the VA's Special Therapeutic and Rehabilitation Activities Fund. There is no provision for any guaranty as to the solvency of this new fund or any provision for the reimbursement to the National Service Life Insurance Fund in the event of a loss.

Under the terms of this bill, the National Service Life Insurance Fund will be used for purposes other than those intended, have no guarantee against loss and receive a lower rate of interest. As trustee, the Administrator strongly opposes any such proposal. This proposal violates the integrity of the trust fund and subjects the millions of policyholders to potential loss. Accordingly, for the reasons specified, we recommend that subsection (c) of the amended section 618, be deleted.

We also have some concern with respect to the proposed subsection (d) of section 618, title 38. This subsection could be construed to authorize educational and training benefits under chapter 31, 34, or 35 of title 38, for patients based upon their participation in a prolonged rehabilitative treatment program. This would be an inappropriate use of a medical treatment program.

Furthermore, the therapeutic work programs should not be considered as having as their basic objective providing long term work to veterans, and is intended to be available only to those veterans who need a short period of rehabilitation to assist them in their efforts to obtain the confidence they need for a successful return to society as a productive member. Education, on the other hand, is geared directly to assisting individuals to reach a professional goal. Accordingly, this provision should be deleted.

In addition to the concerns expressed above with respect to the proposed new statutory language, we also do not favor the special claim settling authority which would be provided in section 108(b) of the bill, to handle any claims we might have against those nonprofit corporations which are involved in the use of patients and members of VA health care facilities in compensated work programs. We believe the authority now provided by the Claims Collection Act (Pub. L. 89-508) and other statutes authorizing the settlement, waiver or

compromise of claims by the Government, are sufficient to handle any claims of the nature spelled out in the bill. We do not believe the proposed new authority is either necessary or desirable.

We would suggest an additional amendment to the bill to culminate a controversy that now exists with respect to the nature of the so-called "Poppy" programs where veterans volunteer to assist veterans organizations in making the poppies which are subsequently sold to raise funds necessary to allow those organizations to provide much needed services to veterans and their families. Some questions have been raised as to whether these activities come within the purview of the Fair Labor Standards Act with its wage rate requirements.

If that law was so applied, we have been advised that it would kill the Poppy programs. Furthermore, those veterans who participate in this program elect to do so in good part because of their support of the veterans organizations. Moreover, the Poppy making activities are completely different from the compensatory work therapy program now carried out by the VA where rates equal to those otherwise required by the Fair Labor Standards Act are paid. However, to eliminate any confusion, it is suggested that language be added to this bill exempting the Poppy programs from the provisions of the Fair Labor Standards Act.

Section 109 would amend section 620(a) of title 38 to increase the maximum cost of nursing home care in any public or private installation not under the jurisdiction of the Administrator from 40 percent of the cost of care furnished by the Veterans' Administration in a general hospital under the direct jurisdiction of the Administrator to 45 percent of the cost of such care, or not to exceed 50 percent of such cost in geographical areas as determined necessary by the Administrator upon recommendation of the Chief Medical Director, to provide adequate care.

The restriction limiting the cost of community nursing home care to 40 percent of the cost of care furnished in a VA facility has, in a few localities, restricted our ability to provide needed nursing home care to veterans. The subject bill would enable us to provide nursing home care in those localities, and would provide needed flexibility for the VA to parallel other Federal/State public assistance payments, and compete for skilled nursing beds in community facilities.

Since costs in most areas can now be met within the 40 percent of costs of care in VA facilities limit as currently provided by law, there are only a few localities where the new 45 percent limit proposed in the bill would be used. Therefore, there is no need at all for the authority to pay up to 50 percent of hospital costs in some geographical areas. While we favor the increase to 45 percent, we do not favor the additional increase to pay up to 50 percent of hospital costs in some areas. The cost of the subject section, if enacted, would be minimal.

Section 109 would also add a new subsection (e) to define nursing home care to include intermediate care as determined by the Administrator. The cost of such intermediate care for purposes of payment by the United States shall be determined by the Administrator except that the rate of reimbursement shall be commensurately less than that provided for skilled nursing home care as defined in section 101(28) of title 38. We support this amendment which would allow us to contract for an intermediate level of nursing home care, but would sug-

gest, as a technical matter, that the word "nursing" be added immediately after the word "intermediate" in the first and second sentences.

Because of the VA's high demand for skilled community nursing home care beds which we have not been able to meet, the addition of the intermediate level of care could improve the cost effectiveness of our community nursing home care beds available.

It is estimated that 30 percent of the present community nursing home placements require only intermediate nursing care. Assuming continuation of the planned census through 1981 and an average saving of \$4 per diem for these 30 percent placements being made into ICFs, annual cost containment would be as follows:

<i>Community Nursing Home Care</i>		<i>Cost containment¹</i>
Fiscal Year and ADC:		<i>Proposed legislation</i>
1976—2,100	-----	\$772, 800
1977—2,400	-----	3, 504, 000
1978—2,700	-----	3, 942, 000
1979—3,000	-----	4, 380, 000
1980—3,300	-----	4, 831, 200
1981—3,600	-----	5, 256, 000
Total	-----	22, 686, 000

¹ Cost containment: Based on a cost difference of \$4 per patient day for intermediate care, and on the assumption that intermediate care will be substituted for skilled care for 30 percent of those veterans who would otherwise be provided skilled care.

As a technical matter, it is suggested that the term "general hospital" as used in 38 U.S.C. 620(a)(2)(C)(ii) be changed to "the inpatient bed section of a Health Care Facility". Such change would reflect the terminology now being used within the Veterans' Administration.

We favor the enactment of section 109.

Section 110(a) would amend subsection (b) of section 624 of title 38 to authorize the Administrator to furnish hospital care and medical services to any otherwise eligible veteran for a service-connected disability if the veteran is in Mexico or Canada.

Under the current law (section 624(b) of title 38) the Administrator can furnish hospital care and medical services to any otherwise eligible veteran for a service-connected disability if the veteran (1) is a citizen of the United States sojourning or residing abroad, or (2) is in the Republic of the Philippines.

We do not endorse providing medical treatment for service-connected disabilities to non U.S. citizens who served in U.S. forces residing in Canada or Mexico. While we acknowledge our close national ties with Mexico and Canada this may establish a precedent for providing such benefits to citizens of many other nations, which in our opinion is not justified.

The enactment of section 110(a) would result in the following estimated costs:

Transition quarter	-----	\$302, 000
1st year	-----	1, 206, 000
2d year	-----	1, 206, 000
3d year	-----	1, 206, 000
4th year	-----	1, 206, 000
5th year	-----	1, 206, 000

Section 110(b) would amend section 641 of title 38 to eliminate the present requirement that a veteran be a "veteran of any war" before VA will reimburse a State home, and increases the amounts paid by the Veterans' Administration to States for the care and treatment of eligible veterans receiving such care in State homes. It would increase the VA reimbursement from the current \$4.50 per diem rate to \$5.50 for domiciliary care; from \$6.00 to \$8.00 for nursing home care; and from \$10.00 to \$11.00 for hospital care. No payments would be made in excess of one-half of the cost of the veteran's care in such State home. The Administrator would apply the definition of nursing home care set forth in section 5031(5) with respect to determining the rate of per diem payable. We do not favor this provision for reasons discussed later.

Section 110(b) would also amend section 642(a) of title 38 to provide that no payment or grant may be made unless the State home is determined by the Administrator to meet such standards as the Administrator may prescribe, which standards with respect to nursing home care shall be no less stringent than those prescribed pursuant to section 620(b) of title 38. We do not object to this provision.

The change in the maximum per diem rate payable under section 641(a) of title 38 would be effective as of January 1, 1976.

Section 110(c) would amend section 5031 of title 38 to expand the definition of construction of new buildings to include buildings not presently used for providing nursing home care and would add a new paragraph to section 5031 to define the term "nursing home care" to include domiciliary care provided in any State in which no Veterans' Administration hospital or domiciliary facility is located. We favor this provision.

Presently, the VA can provide up to 65 percent of the costs for construction of new nursing home facilities. It can provide up to 65 percent for remodeling, modification, and alteration of existing hospital or domiciliary facilities. Alaska and Hawaii presently have no VA hospital or domiciliary facilities. Therefore, this provision would allow VA to participate with these two States in the construction of State home facilities to provide domiciliary care as well as the presently authorized construction of nursing home facilities.

Section 110(c) would also amend section 5034 of title 38 to provide that general standards for furnishing of nursing home care in facilities which are constructed with assistance received under subchapter III of chapter 81 shall meet such standards as the Administrator shall prescribe. Such standards shall be no less stringent than those standards prescribed pursuant to section 620(b) of title 38, except that facilities constructed with assistance received pursuant to the definition in section 5031(5) of title 38 shall be deemed to meet such standards. The Administrator would be permitted to inspect any State facility constructed with assistance provided under subchapter III at such time as the Administrator deems necessary. We favor this provision.

Section 110(c) would also amend section 5035(c) to provide that the Administrator shall waive application requirements set forth in subsection (a)(4) of section 5035 in the case of an application from any State described in section 5031(5) of title 38 to the extent that such State provides reasonable assurance that the portion of the facility constructed with assistance received under subchapter III will be

used principally for veterans and that not more than such proportion as the Administrator shall deem reasonable (not more than 50 percent) of the bed occupancy at any one time will consist of patients who are not receiving care as veterans.

We believe the present rate structure is sufficient to provide an adequate level of care and are not aware of any specific documentation by the States that the proposed new rate structure, or eligibility criteria eliminating the war-time service requirement, would provide an increased quality of care. Furthermore, it is obvious that enactment of the proposed rate increase would result in major cost increases to the VA, at a time when the President is urging substantial reductions in the growth of Government spending as a step toward balancing the Federal Budget.

In view of the foregoing, we are opposed to the aforementioned increase in the per diem rate structure. We are also opposed to the liberalization in the eligibility criteria which would make peace-time veterans eligible for inclusion in the program.

Enactment of the increased per diem rate would result in the following estimated costs to the Veterans' Administration:

Fiscal year:	Cost increase
1976 transition quarter-----	\$1, 629, 000
1977 -----	7, 301, 000
1978 -----	7, 663, 000
1979 -----	7, 945, 000
1980 -----	8, 232, 000
1981 -----	8, 293, 000
Grand total-----	41, 053, 000

As a purely technical matter, if the provision deleting the "veteran of any war" reference is enacted, it would be necessary to make a similar change to the definition of State Home found in 38 U.S.C. 101 (9).

Section 111 would amend chapter 17 of title 38 to add a new subchapter to provide for a Preventive Health Care Program. The purpose of the subchapter, as outlined in section 660 of subchapter VII, is to assure the best possible health care for veterans with service-connected disabilities by furnishing them preventive health care services. The Administrator would be authorized under the program to determine the cost-effectiveness and medical advantages of furnishing preventive health care services to veterans and persons eligible for hospital and medical care and services under title 38.

Under the definition of the term, "preventive health care services" contained in section 661, those services may include, but are not limited to, periodic medical and dental examinations; patient education and awareness heightening techniques; maintenance of drug use profiles, patient drug monitoring, and drug utilization education, mental health preventive services; substance abuse prevention measures; immunizations against infectious disease; prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature; genetic counseling concerning inheritance of genetically determined diseases; routine vision testing and eye care services; and nutrition education and counseling services.

Such term may also include periodic re-examination of likely target populations for selected diseases and for functional decline of sensory organs, together with attendant appropriate remedial intervention

and such other medical services as may be necessary for providing effective and economical preventive health care.

Section 662 would authorize the Administrator to furnish, on an inpatient or ambulatory basis, such preventive health care services as are feasible and appropriate to any veteran in connection with the treatment of a service-connected disability and to any veteran described in section 612(f) (2) of title 38. The Administrator would also be authorized to carry out a pilot program mentioned above, involving all veterans eligible for care under chapter 17, to determine the cost effectiveness and medical advances of preventive health care. In carrying out the preventive health care program, the Administrator would be authorized to utilize interdisciplinary health care teams composed of various professional and paraprofessional personnel, especially public nurses, psychologists, optometrists, technicians, physician assistants, and expanded-duty dental auxiliaries.

Section 663 would require the Administrator to include, in the annual report to Congress, a comprehensive report on the administration of the program, including such recommendations for additional legislation as the Administrator deems necessary.

Section 664 provides that the authority to carry out a pilot program may not be used after the last day of the tenth fiscal year following the fiscal year in which subchapter VII is enacted.

The cost of section 111 is as follows:

1st year-----	\$92, 365, 000
2d year-----	100, 172, 000
3d year-----	107, 979, 000
4th year-----	115, 714, 000
5th year-----	123, 521, 000

In spite of an increased attention to prevention and detection programs, there is a paucity of valid data relative to the cost effectiveness, medical advantages, or proper scope of preventive health programs which have the purposes of improving health status and reduction of overall costs by eliminating the need, in many cases, for subsequent expenses, therapeutic procedures, medical services and facilities. We therefore are opposed to enactment of section 111 of this bill. We would not object to a provision requiring the VA to develop a design to determine the appropriate scope, medical advantages and cost effectiveness of a pilot program for seriously disabled veterans aimed at the prevention of preventable diseases and accidents, the individual awareness to ameliorate those environmental factors natural and manmade, contributing to ill health, the early detection and of treatment of acute diseases and treatment of chronic ailments before they become severe enough to require expensive and extended medical care.

Section 112 would amend section 1903(e) of title 38 to authorize the Administrator to obtain, by purchase, lease, gift, or otherwise, any automobile, motor vehicle, or other conveyance deemed necessary to carry out the purposes of the subsection, and to authorize the Administrator to sell, assign, transfer, or convey vehicles to which the Administrator obtains title for such price and upon such terms as is deemed appropriate, with any proceeds to the Government received therefrom credited to the applicable Veterans' Administration appropriation.

We cannot favor this provision, since we believe that the procurement and disposal of the required vehicle should be handled in a manner consistent with normal Government procurement procedures, utilizing the service of the General Services Administration.

Section 113 of the bill, would restructure and make substantive amendments to section 3301 of title 38.

Clause (3) of section 113 would redesignate paragraphs (6), (7), (8), and (9) of section 3301 of subsections (c), (d), (e), and (f). No comment is made in the bill as to the retention, deletion or redesignation of paragraphs 1 through 5 of section 3301. If those paragraphs are to be retained, then presumably they would be subsections of the new (b). However, if that is, in fact, how section 3301 will be structured, we fail to see any reason for splitting the exemptions into two categories so that five are designated by numbers and four are designated by letters. The present state of section 3301 with nine exemptions numbered 1 through 9 would seem to be a reasonable and less confusing approach.

Regarding the new subsection (f), as proposed in section 113(5) of the bill, we have no objections to the proposed substantive changes. This provision would change the law to allow the Administrator to release the names and addresses of veterans and their dependents to any Federal, State, or local government agency if the Administrator deems the release to be necessary or appropriate for the protection of the public health or safety to provide for the release of names and addresses of veterans to nonprofit organizations for research purposes and for followup purposes of medical registries.

Participation in such registries (cancer, hypertension) have direct bearing on patient education and preventive medicine programs, as well as patient care. The wording of subsection (f) is substantially in accord with changes suggested by this Agency in reporting on other bills relating to the confidentiality of VA records. We, therefore, find no objection to it.

Regarding the proposed subsection (g), it is felt that by requiring release under section 3301 to be in accordance with the provisions respecting routine uses in section 552a of title 5, problems may arise in the future. Should the Courts or Congress restrict the nature of routine uses, the ability to release information under 3301 itself would be correspondingly limited. In addition, there are provisions in the Privacy Act which would allow release of certain information without the necessity of establishing routine uses. However, if this section is enacted, the VA would apparently have to establish routine uses for all releases. We feel that the following language would be preferable in that it would establish the requirement that the Privacy Act provisions be adhered to! "Any disclosure made pursuant to 38 U.S.C. 3301, as amended by this bill, shall be made in accordance with the provisions of 5 U.S.C. 552a."

Section 114(a) of the bill would amend subchapter I of chapter 73 of title 38.

Paragraph (1) would amend section 4106(b) of title 38, United States Code, by inserting four new paragraphs. Paragraph (1) would reduce the probationary period of physicians, dentists, nurses, physician assistants, and expanded-duty dental auxiliaries from 3 years to

2 years. Moreover, it would provide that periodic review of the record of probationary personnel be made by a board composed of personnel of comparable or higher grade than the probationary employee; and that in addition to being separated, probationary personnel who are not performing satisfactorily for reasons relating to professional competence or performance could be reassigned. In addition, other action consistent with continuing the employment of such persons in a capacity in which such persons can effectively function could be taken. Action taken pursuant to this paragraph would not be considered disciplinary, and since probationary employees do not have property in their positions as defined in *Board of Regents v. Roth*, 408 U.S. 564 (1972), and *Perry v. Sinderman*, 408 U.S. 593 (1972), and action based upon professional inadequacies, does not infringe the liberty rights of the employee, as defined in the same cases, they would be provided only the procedural protections prescribed in proposed paragraphs (2) and (3) of this section.

New paragraph (2) would define the rights of probationary personnel when it is proposed that separation, reassignment, or other action as described in paragraph (1) of the proposed subsection be taken for reasons relating to professional competence or performance pursuant to paragraph (1). As we construe this proposed paragraph, the right to a statement of supporting reasons in writing included in this paragraph would not be a specific statement of formal charges but rather a general statement of reasons which may be in the form of conclusions.

Also included is the right to reply to the statement either orally or in writing.

An oral presentation would not preclude the right to offer a written statement, or vice versa. While we do not specifically object to this choice of rights, we would think that either one or the other would be sufficient. The right to assistance which has been included would allow the employee to choose another individual to do, or assist the employee in doing, the things allowed by this section and implementing regulations. It is parenthetically stated that the right to assistance of another person will not be at Government expense. As a technical matter, we would suggest that the language on page 28, line 24, should be amended by adding immediately before the parenthesis, "except for salary" to insure that a Federal employee could be selected to assist the employee. A similar change should be made on page 30, line 20.

New paragraph (3), as we construe it, would clarify the options of the Chief Medical Director with regard to the recommendations of the board, i.e., to accept, reject or modify the recommendations of the board, or to require the board to consider the matter further.

New paragraph (4) would provide that when it is proposed to take disciplinary action against probationary personnel on grounds of misconduct rather than professional competence or performance, the procedures of section 4110 shall apply.

Although probationary personnel do not have property rights in their positions, the courts have indicated that separation from Federal service on certain grounds of misconduct would infringe upon their liberty rights under the 5th Amendment by stigmatizing them. Because of the difficulty of determining in which cases a finding of misconduct

would result in stigma to the employee, and because of the unpredictability of the Federal courts on this issue, a hearing would be provided in all cases of misconduct not related to professional performance or competence.

Under the current law (38 U.S.C. 4106(b)) and regulations, the extent of the authority of the VA in taking actions against probationary employees is unclear. The law provides that if the employee is not found fully qualified and satisfactory by the board reviewing the employees performance, the employee shall be separated from service. This could be construed to limit the agency from taking any steps to salvage or rehabilitate marginal employees. This bill would provide such authority. Under current regulations, various reviews of the probationary employee are required. If serious deficiencies are noted in a review, the employee is entitled to notice of a board review and of the reasons therefor. The employee is entitled to respond to the VA's reasons orally or in writing, according to the regulation, but is not entitled to representation or assistance. This bill, as we understand it, would allow both an oral and written response and would allow the employee to secure assistance at his or her own expense to assist him or her in the preparation and presentation of his or her case. We would construe this provision to allow the person assisting the employee to do the things the employee is entitled to do, i.e., prepare the written statement, makes the oral statement to the board, or both.

Paragraph (2) of section 114(a) of the bill would amend section 4110 of title 38, U.S.C. The proposed amendment would include as grounds for taking disciplinary action, other such cause as will promote the efficiency of the service, in addition to inaptitude, inefficiency, and misconduct which the section currently specifies. The proposed new basis for disciplinary action appears to be the same as is provided in 5 U.S.C. 7501 which is the basis for disciplinary action against regular civil service employees. In addition, it would state clearly that the provisions of section 4110 of such title would apply to persons appointed under section 4104(1) of title 38, who have completed the probationary period as provided for in section 4106(b) of such title. The proposed amendment would also broaden the application of section 4110 to probationary personnel appointed under section 4104(1) of title 38, and to residents and interns appointed under section 4114(b) of such title, who are subject to disciplinary actions on grounds of misconduct. Under this section, as amended, the Chief Medical Director continues to have responsibility for appointing disciplinary boards.

Section 4110(b) as amended, would continue the provision that disciplinary boards shall consist of from 3 to 5 members, but would add that the members must be persons of comparable or higher grade than the person charged. Under this section a majority of the members of the board will be of the same profession as the person charged. The Chief Medical Director would continue to select the members of the board.

Section 4110(c), as amended, would provide that the Chief Medical Director shall appoint the Chairman of the board who shall be a member of the same profession as the person charged. (This requirement does not appear to be appropriate in the case of physician assist-

ants and expanded-duty dental auxiliaries.) A majority of the board would elect a secretary from among its members and the Chairman and secretary shall have authority to administer oaths to witnesses before the board. The Chief Medical Director may designate or appoint one or more investigators to assist the board in the collection of evidence. The section also authorizes the VA to appoint counsel to represent the agency. These provisions are currently in either the law or regulations:

Section 4110(d), as amended, would provide a person under charges the right to: (1) a specification of the charges, (2) a full hearing with opportunity to produce supportive witnesses and confront and cross-examine agency witnesses, and (3) representation throughout the procedure, not at Government expense. These rights are, in our opinion, currently required by law and regulation and are essential to meet the fundamental requirements of due process.

Section 4110(e), as amended, would provide procedures for the board and the Chief Medical Director when a board sustains any charge against an employee. Under this section the board would recommend to the Chief Medical Director such disciplinary action as it deemed appropriate. The option of the Chief Medical Director regarding the board's recommendation are:

(1) approve such recommendations and findings, (2) approve such recommendations and findings with modification or exception and, (3) disapprove the findings and recommendation and take appropriate action. The section would allow the Chief Medical Director to refer the matter back to the board for reconsideration in the event the Chief Medical Director took exception to any finding of fact of the board. If, after the board reconsiders, the Chief Medical Director continues to disagree, he or she may make his or her own independent review of the record before making a decision. We believe the Chief Medical Director would be within his authority following these procedures under current law, but the proposed amendment would clarify the matter. The section would also provide that the decision of the Chief Medical Director is the final agency decision. We would recommend that this be amended to provide for an appeal of the decision of the Chief Medical Director to the Administrator who would make the final agency decision. We would be happy to assist the Committee staff in drafting the necessary technical amendments.

Section 4110(f) is a new section which, as we understand it, would provide that although reassignment may be used as a disciplinary measure by the Chief Medical Director, under the procedures of 38 U.S.C. 4110, not all directed reassignments are disciplinary in nature requiring a hearing under section 4110. This section would provide that a directed reassignment which results in a reduction in grade or salary or relative standing in the department for a person who has completed the probationary period prescribed in 4106(b) of this title, would require a hearing under section 4110.

The section would also provide a new remedy for the employee in that when a person alleges that a reassignment not involving a reduction in grade, salary or relative standing in the department, directed for the good of the service is actually disciplinary or punitive in nature, such person may contest the reassignment under appropri-

ate grievance procedures. If the person is sustained in the grievance proceeding, he would be entitled to the procedures of section 4110. This section would also define "reassignment" as a transfer of a person from one duty station to another or from one set of responsibilities to another within the Department of Medicine and Surgery. We would construe this definition as including both geographical moves and changes in duty assignments.

This section of the bill would change the law in several important aspects. It would add "such cause as will promote the efficiency of the service," to the existing grounds of inaptitude, inefficiency, and misconduct upon which to base a disciplinary action. We favor this addition because it would clarify the basis upon which disciplinary actions could be brought. There is an existing body of case law relating to "cause" which would be of value to the agency in litigation over personnel matters.

This section of the bill would also extend the coverage of its provisions to probationary personnel appointed under section 4104 and to residents and interns appointed under section 4114(b) of this title, against whom disciplinary action is being taken on grounds of misconduct. In addition to the fact that the provision would provide the employee a recourse or right to further consideration of his side of the story when agency action is being taken which might be stigmatizing in nature, we believe this provision desirable because the burden placed on the VA by these provisions would be negligible. Furthermore, we believe these changes are required if we are to be able to meet the challenge of these employees that our current procedures may violate their Constitutional rights.

The provisions relating to the board and the powers of the Chief Medical Director are largely cosmetic. These provisions spell out in more detail procedures and options of the existing statute and regulations. We favor these revisions, although we would recommend that the board secretary also be appointed by the Chief Medical Director.

The proposed section 4110(f) is an attempt to clarify the subject of directed transfers. Statutory guidance in this area is badly needed and we favor the approach taken in this bill.

Paragraph (3) of this section of the bill would amend section 4114(b) of title 38, by redesignating paragraphs (2) and (3) as paragraphs (3) and (4) and inserting a new paragraph (2).

The new paragraph (2) authorizes the Chief Medical Director to cause to be appointed House Staff Review Committee which will review the academic and professional performance and progress of house staff. This new paragraph parallels section 4106(b) of title 38, and extends the same rights to residents and interns as are extended to probationary personnel under section 4106(b) with the exception of permanent employment status.

We favor this revision because it will establish clear guidelines for dealing with residents and interns and by affording the rights provided in this section, some litigation challenging the constitutionality of our current procedures may be averted.

Section 114(b) of the bill provides effective dates of subsection (b) with respect to the period of probationary service for probationary employees serving in the probationary period as of the date of enact-

ment of this bill. For those employees who, on the date of enactment of this Act, have served 18 months or more of their probationary period, subsection (a) of section 114 of this bill becomes effective 180 days after the date of enactment of this bill. For those employees who have served less than 18 months of their probationary period as of the date of enactment, subsection (a) of section 114 of this bill becomes effective upon the date of enactment of the bill.

We favor this section of the bill.

Section 115 would amend section 4107(e) of title 38 by inserting a new paragraph (10) which would provide that the provisions of the subsection would apply, in lieu of the provisions of sections 5542, 5543, 5545(a) (b) and (c), and 5546 of title 5, with respect to any person employed in the Department of Medicine and Surgery, except for physicians and dentists, whose principal responsibilities relate directly to patient care. The payment of premium pay for the employees involved would thus be governed by the title 38 subsection cited above, now applicable to nurses, physician assistants, and expended-duty dental auxiliaries, rather than the quoted section of title 5.

Section 115 would also amend section 4107 by inserting a new subsection (g) which would provide that, when the Administrator finds such action to be necessary in order to provide hospital care and medical services for veterans, the Administrator shall increase the minimum or maximum rates of basic pay authorized under chapter 73 of title 38 or title 5, on a nationwide, local or other geographic basis. Such rates shall be increased for one or more grades or for one or more medical, dental or health care fields within the grades to provide rates of basic pay commensurate with competitive pay practices in the same occupation or in order to achieve internal alignment of rates of basic pay within the Department of Medicine and Surgery, or to meet staffing requirements at Veterans' Administration facilities. Any such increase in the minimum rate of basic pay for any grade may not exceed the maximum rate prescribed by law for such grade, while any such increase in the maximum rate of basic pay for any grade may not exceed in corresponding amount, the rate provided for in the statutory range for that grade, subject to the limitation on the rate of basic pay fixed by administrative action set forth in section 5363 of title 5.

In our view, we believe the two amendments proposed by section 115 of the bill are undesirable for the following reasons:

We recognize there are differences in premium pay for Department of Medicine and Surgery nurses and other personnel of our health care facilities. However, the extension of DM&S nurse premium pay provisions to other patient care personnel (other than physicians and dentists) would not eliminate the differences, and we would continue to have personnel working side-by-side who would be eligible for different premium pay provisions, i.e., General Schedule personnel not considered to be in direct patient care activities and personnel subject to the Federal Wage System would continue to be subject to appropriate premium pay provisions of title 5. In addition, such special treatment for DM&S patient care personnel would not be available to similar or other General Schedule personnel of other Federal agencies. Moreover, such a change would be premature in light of the comprehensive premium pay study by the Comptroller General, as required by Public Law 94-123, and also the study by the Civil Service Com-

mission as a part of its responsibility for review of the Federal pay comparability process and as further recommended by the President's Panel on Federal Compensation in its December 1975 report to the President.

The special rate and rate range authority proposed in new subsection (g) of section 4107 of title 38 is substantially duplicating that pertaining to the General Schedule, Department of Medicine and Surgery schedules, and Foreign Service schedules vested in the President in 5 U.S.C. 5303 and delegated to the Civil Service Commission under the provisions of Executive Order 11721.

However, the basis for establishing special schedules under the proposed subsection (g) is broader than the Commission's authority because it would permit the establishment of special schedules when not required for recruitment but merely for internal alignment or staffing requirement purposes. To the extent this proposed authority would duplicate the Commission's authority, it would be unnecessary and undesirable, since we have had reasonable success in obtaining Commission approval of special schedules when necessary to be comparable with non-Federal pay levels. This provision, moreover, would not contribute to internal alignment and staffing, because our major problem relates to the differences in pay between personnel subject to the General Schedule and those subject to the Federal Wage System. The relationship between white and blue collar employees is an extremely complex problem, not only for the VA but also for other Federal agencies and for non-Federal employers, as well. To implement one of the recommendations of the President's Panel on Federal Compensation, the Civil Service Commission is preparing legislation which would authorize the establishment of locality schedules for General Schedule employees in certain occupations. We are uncertain as to the impact on VA of such a proposal, nor can we predict the results of the study of basic pay by the Comptroller General, also required by Public Law 94-123. Accordingly, the enactment of this proposal would appear to be premature and inappropriate at this time, and we are opposed to its enactment.

We would estimate that enactment of this section would result in yearly cost of \$7 million for premium pay provisions and \$30 million for special schedule authority, or 5-year cost of \$35 million and \$150 million, respectively.

Section 116 would amend section 4114(b) (1) of title 38 to authorize the Administrator to establish rates of pay retroactively for residents and interns serving in the Department of Medicine and Surgery.

Under section 4114(b) of title 38, the Administrator has the authority to establish the amount and terms of pay for residents and interns training in VA hospitals. Since 1968, rates of pay for residents and interns have been determined on a locality basis from data submitted on pay and fringe benefits of a designated index hospital in a community. Inasmuch as these local salary schedules are administratively determined rates of pay, various decisions by the Comptroller General prohibit the setting or establishing of these pay schedules retroactively. Nevertheless, in increasing numbers, VA index hospitals are engaging in formal negotiations with resident and intern associations regarding pay and fringe benefits in their institutions. In many cases,

the parties do not agree to a contract until after the effective date of the proposed increases, thereby causing a retroactive salary adjustment. VA has been unable to match these retroactive adjustments, thus leading to dissatisfaction among our residents and interns at affected stations. Accordingly, we favor the enactment of this section of the bill.

Enactment of this amendment would not, in our opinion, result in any increased cost to the VA. Under the present conditions, we endeavor to anticipate the pay scale for residents and interns as of the effective date of the proposed retroactive pay scale of the index hospital, and pay that scale. In some cases our estimates have been too high, while in others it has been too low, distributed about equally.

Section 117 would amend chapter 73 of title 38 to add a new subchapter III entitled—Protection of Patient Rights.

Section 4131 of subchapter III would direct the Administrator upon the recommendation of the Chief Medical Director, to prescribe regulations establishing procedures to ensure that all medical and prosthetic research and, to the maximum extent practicable, all patient care furnished under title 38 shall be carried out only with the full and informed consent of the subject/patient or an appropriate representative.

We are not opposed to this amendment, since it would result in no basic change in our practice. We believe, however, that such amendment is unnecessary.

Section 4132 of subchapter III provides that records of the identity, diagnosis, prognosis, or treatment of any patients which are maintained in connection with a program or activity relating to drug abuse, alcoholism or alcohol abuse or sickle cell anemia education, training, treatment, rehabilitation, or research shall, except as described below, be confidential. It will replace, for Veterans' Administration purposes, the provisions of law in two other titles of the United States Code as the statutory bases for confidentiality of drug and alcohol abuse records of patients treated by VA medical facilities.

Those provisions are, respectively, sections 333 and 408 of Public Law 93-282 (21 U.S.C. 1175, for drug records; 42 U.S.C. 4582, for alcohol records). Sections 2.1-2.67 of title 42, Code of Federal Regulations issued by the Secretary of Health, Education, and Welfare are currently the authority for VA action in these two areas.

Section 4132(a) adapts the existing law, with virtually identical language in the case of alcohol abuse records, to the Veterans' Administration specifically, and adds nothing new to the substantive requirements for confidentiality of these records. Whereas section 333 of Public Law 93-282 referred to records "... maintained in connection with the performance of any drug abuse prevention function ..." section 4132(a) will apply the language now used in section 408 of Public Law 93-282 to both drug and alcohol patients. The new section will pertain to records "... maintained in connection with the performance of any program or activity relating to drug abuse, alcoholism or alcohol abuse ... education, training, treatment, rehabilitation, or research. . . ." The new provision is seemingly more extensive as it applies to drug abuse treatment records. It should be viewed as a clarifying provision which will insure that the same standards are applied to both classes of records. Section 4132(a) also applies to sickle cell anemia records.

Section 4132(b) permits the disclosure of such record, in accordance with the prior written consent of the patient according to regulations prescribed by the Administrator. The record may also be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency. It may also be disclosed to qualified personnel for research, audit, or program evaluation purposes but such personnel may not identify an individual patient in any manner.

Section 4132 also provides that the content of such record may be disclosed by an appropriate order of a U.S. court of competent jurisdiction after the court determines the need for such disclosure and imposes appropriate safeguards against unauthorized disclosure. Provision is also made for the disclosure of the record of a deceased patient upon the prior written consent of the personal representative of such patient if the Administrator determines such disclosure is necessary for survivor benefits. While the other provisions of the new section 4132 are based on existing law as cited, section 4132(b) (1) (3) is an original provision, having no precedent in Public Law 93-282 or otherwise. It establishes criteria for disclosure of drug and alcohol abuse and sickle cell anemia records pertaining to deceased persons. No such record may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient except as authorized by a U.S. court such as referred to above.

The prohibitions of section 4132 continue to apply to records of a former patient. The section does not apply to any interchange of records among Veterans' Administration facilities furnishing health care to veterans or between such facilities and the Armed Forces. Section 4132(e) is almost exactly a duplication of Public Law 93-282. In subsection (e) (2), however, "components" is changed to "facilities". This amendment would seem to restrict transmission of information without the individual's consent to personnel within the medical programs. The word "facility" is more restrictive than "component", and indicates only institutions or clinics which provide medical treatment. It would unequivocally forbid routine disclosure to other departments within the Veterans' Administration which do not provide health care.

Finally, section 4132 provides for a fine for any person who violates any provision of the section or any regulation issued pursuant thereto. The fine shall be not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

Section 4133 of subchapter III provides that alcohol and drug abusers who are suffering from medical disabilities shall not be discriminated against in admission or treatment solely because of their alcohol or drug abuse or dependence, by any Veterans' Administration health care facility. It also provides that the Administrator shall prescribe regulations for the enforcement of this nondiscrimination policy.

Section 4134 of Subchapter III provides that Veterans' Administration regulations issued to protect patients' rights shall, to the maximum extent feasible, make applicable the regulations governing human experimentation and informed consent prescribed by the Secretary of Health, Education, and Welfare, and the confidentiality of drug and alcohol abuse medical records and the admission of drug

and alcohol abuses to private and public hospitals, prescribed pursuant to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and the Drug Abuse Office and Treatment Act of 1972. Section 4134 also directs the Administrator, in prescribing and implementing regulations, to consult with the Secretary of Health, Education, and Welfare, and the Director of the Special Action Office on Drug Abuse Prevention and to submit a full report, with respect to the regulations, to the appropriate House and Senate committees. Since regulations were already required to be issued in conjunction with the Secretary by Public Law 93-282, with a report to the Congress, the main difference is the need to include sickle cell anemia records within these regulations.

We are not opposed to this amendment, except that portion providing for interchange of records. As presently written, there could be no interchange or records between VA Health Care Facilities and the VA Department of Veterans Benefits nor the VA Board of Veterans Appeals. Additionally, we question if we could even process our own DM&S information to the VA Department of Data Management.

The VA is in compliance with the HEW regulations, accordingly this amendment to title 38 would result in no change in our practices. We strongly favor the provision which provides for an exception to the confidentiality rule for the purpose of conducting scientific research.

There would be no additional cost to the VA since the procedures specified are now being followed.

Section 118 would amend section 4123 to provide that proceeds received from the training personnel at Regional Medical Education Centers shall be credited to the applicable Veterans' Administration medical appropriation.

Under current law, the VA is authorized to be reimbursed for training non-VA personnel in VA regional medical education centers. The moneys received for such services go directly to the Treasury as miscellaneous receipts which is standard fiscal procedure.

We feel the procedures now required are consistent with sound fiscal procedure and see no reason to change them. Therefore, we do not favor the suggested change.

Section 119 of the bill would amend section 4204 of title 38. A new subsection (b) would authorize the Canteen Service to incur obligations in excess of budgetary resources. Section 119 would also amend section 4206 of title 38 to delete the first and last reference to "year" and to insert a reference to "years." This would permit a multi-year budget plan. In addition, section 119 would add a new sentence at the end of section 4206 of title 38 which will authorize the Veterans Canteen Service to provide capital improvements to canteen facilities, including items which are constructed and become a part of the building or structure.

While these proposals would, at first glance, provide some additional flexibility in the fiscal procedures now applicable to the canteen service, we are not certain that they would provide the most desirable approach. Furthermore, we believe there may be other options now available to us under present authority. Additionally, this year we are reviewing our construction process with the aim of improving the

planning, cost projection, and efficiency of the entire process. We would prefer to address the problem of funding canteen construction in the context of this broader review. Accordingly, we feel any action directed to the fiscal or construction procedures applicable to the canteen service is inappropriate at this time.

Section 120 of the bill would amend section 5001(a)(3) of title 38, to require the Administrator, subject to the approval of the President, to establish and operate not less than 10,000 beds in fiscal year 1977, and in each fiscal year thereafter, for the furnishing of nursing home care to eligible veterans in facilities over which the Administrator has jurisdiction. Current law requires the establishment and operation of not less than 8,000 VA nursing home care beds in the fiscal year ending June 30, 1974, and in each fiscal year thereafter.

Since the objective of this section can be accomplished, and, in fact, is being accomplished under current law, we do not consider this provision to be either necessary or desirable. The President has authorized the establishment and operation of 10,000 VA nursing home care beds and we are planning for expansion accordingly. However, due to several factors, including necessary construction and modification of facilities, and a medically desirable balance of community and VA operated beds, we will not be in a position to reach the 10,000-bed level in fiscal year 1977.

In view of the foregoing, we are opposed to this section of the bill.

Enactment of this section would result in the following estimated costs to the VA:

Fiscal year:

Transition period	8,534,417
1977	34,390,811
1978	34,776,105
1979	35,015,253
1980	35,284,376
1981	35,892,129

Section 121 of the bill would amend subchapter IV of chapter 81 of title 38.

Subsection (a) would amend section 5053 by authorizing in subsection (a) of that section the Administrator to enter into an agreement with other hospitals, medical schools, or clinics in the community for the mutual use, or exchange of use, of specialized or other medical resources when such agreement will obviate the need for a similar resource to be provided in a VA facility, or where such specialized or other resource is in a VA facility and has been justified on the basis of veterans' care, but is not utilized to its maximum effective capacity. Under current law the sharing agreement can apply only to specialized medical resources. This provision would expand that authority to encompass also any other medical resource.

This subsection of the bill would also add new subsections (d) and (e) to the current section 5053 of title 38. New subsection (d) would require the Administrator 30 days before entering into an agreement to share medical resources other than specialized medical resources, in VA health care facilities, to publish in the Federal Register the subject matter and justification for the proposed agreement. It would also require the agreement to (1) specify that any veteran would continue to get priority in the VA facility, according to the formula con-

tained in section 612(i) of title 38, and (2) specify that veterans treated in a community facility would be referred in the priorities set in such section 612(i), (3) be for a period not to exceed 1 year, and (4) not be renewed until a full report on the effect of the arrangement has been transmitted to the Committee on Veterans' Affairs of the Senate and House of Representatives.

We cannot support this amendment as introduced because we believe it could lead to serious problems for both the VA and the communities in which VA facilities are located. For example, it would seem to put us in competition with medical care providers in the communities, and it could lead to the demand for the use of VA medical care beds to the detriment of veteran care. This provision seems directed toward helping the VA resolve a specific problem: The need to staff VA emergency rooms on weekends and evenings in communities where there are adequate resources in non-VA facilities to handle total community needs.

Accordingly, we would suggest that the bill be amended to allow the VA to obtain the use of non-VA emergency room medical care resources when such are not available within VA or other governmental medical care facilities and where it would be economically advantageous to obtain such facilities by contract rather than attempting to provide them through the VA or other Government systems. Any proposal of the nature we have suggested should be limited to allow the use of medical care funds only for the care and treatment of those veterans who would otherwise be eligible for such care if provided within the VA health care facility. Furthermore, it should also be limited to apply only to those veterans who are being treated by the VA, or whose eligibility has already been clearly established. This would include, for example, all veterans who are in need of care for their service-connected disability or for the condition for which they were discharged or released from the active military, naval, or air service, or for veterans who are in a pre- or post-VA hospital care status, or who have a service-connected disability rated at 80 percent or more. It would not include the veteran applying to the VA system for the first time, nor would it apply to the category of care now authorized in that portion of 38 U.S.C. 612(f) (1) (A) which would "obviate the need of hospital admission".

For the reasons indicated above, we do not favor the provisions of the bill as introduced. We would, however, favor an amendment along the lines we have suggested, and would be happy to work with the Committee staff in drafting the necessary language.

Section 121(a) (2), as amended according to the Congressional Record of February 5, 1976, at page S. 1344, also adds a new subparagraph (e) to the present section 5053, title 38, U.S. Code. It would require that medicare payments be made to the VA for hospital care or medical services rendered by the VA to a medicare-covered individual who sought treatment from a non-VA facility, but received some care or services from the VA pursuant to a sharing contract authorized under 38 U.S.C. 5053. The provision appearing in the bill as introduced would have precluded medicare payment if such an individual were a veteran. However, the amended provision requires medicare payment under the above circumstances, even though such individual may also have had title 38 eligibility but proceeded under title 42 entitlement.

The unamended provision would also have excused the VA from having to meet any of the preconditions to medicare payment generally imposed on medicare provider facilities. However, the amended provision would require the Secretary of HEW and the Administrator to jointly prescribe quality control and efficient utilization procedures regarding the treatment for which medicare must pay. It should be made clear that this requirement does not apply beyond the treatment for which medicare reimburses.

Reimbursement rates for such treatment would be set by HEW under consultation with the Administrator. Essentially, this should mean that the service would be rendered and reimbursed for at "reasonable cost". This figure would in effect, become the charge reflected in the VA-non-VA sharing agreement for medicare-covered treatment.

While the VA would continue to be obligated to obtain "full cost reimbursement" under section 5053, the two reimbursement tests can be reconciled. The provision would require that payments be made to either the VA or the nonsharing facility, as indicated in the sharing contract. Presumably, the deductible or coinsurance which the patient is required to pay under medicare would be the responsibility of the facility which receives the payment.

This provision would enable medicare-covered patients to receive the benefits to which they are entitled while enabling VA and non-VA health care institutions to share scarce medical resources in the treatment of such patients by non-VA facilities. This authority will encourage cost control and improved quality of care regarding such patients by avoiding duplication in the acquisition of such resources, and by permitting a concentration of health care provider expertise in these very sophisticated and specialized areas of treatment. The VA is anticipating working with HEW in accomplishing these ends in the sharing programs. We favor this proposal.

Subsection (b) of section 121 of the bill would amend section 5054 of title 38 to provide that any proceeds to the Government received from utilization of the medical information furnished to the surrounding medical community, for which the Administrator is authorized to charge a fee, shall be credited to the applicable VA appropriation. Under current law the fees received for such services are deposited with the Treasury to miscellaneous receipts. The changes made in this subsection would not be consistent with sound fiscal practice and we do not favor its enactment.

Subsection (c) of section 121 of the bill would amend section 5055 of title 38 in order to provide for continuation of funding for the exchange of medical information program through September 30, 1980. The program was authorized by Public Law 89-785, which authorized funding through fiscal year 1971, and extended by Public Law 92-69, which authorized its continuing support through fiscal year 1975. The amendment proposed here would extend the authorization of appropriation of such sums as may be necessary for each fiscal year through 1980.

Exchange of medical information projects have been conducted involving all VA hospitals. These hospitals are either "core" institutions from which information flows to outlying hospitals or are recipients of this information. In every instance, the programs are designed as instruments for the improvement of the delivery and the

quality of health care at peripheral locations. Exchange of medical information activities is also being made available to health professionals in communities surrounding VA hospitals.

Grants authorized under this program are provided to medical schools, hospitals, and research centers, while the pilot programs not funded by grants are conducted at VA hospitals. These activities vary in concept, scope, and content although each has as its objectives the investigation, development, and implementation of innovative programs in exchange of medical information. They cover a wide spectrum of activity.

During fiscal year 1975 the program was funded at \$3 million. It is anticipated that the program would require funding of \$3.5 million for each succeeding fiscal year. The transition quarter (the period beginning July 1, 1976, and ending September 30, 1976) should be funded at approximately \$1,700,000.

We favor this provision of the bill provided it is limited to a 1-year period to allow us to evaluate the program's accomplishments, to determine whether the program should be extended further, modified, or terminated. In accord with this recommendation, the President has requested in his budget, the suggested funding amounts through fiscal year 1977.

Subsection (d) of section 121 of the bill would amend section 5056 of title 38 to change the reference to the Public Health Service Act and eliminate the current reference to the Heart Disease, Cancer, and Stroke Amendments of 1965, and insert a reference to activities carried out under the National Health Planning and Resources Development Act of 1974.

Subsection (e) would insert two new sections in subchapter IV of chapter 81 of title 38.

New section 5058 requires the Administrator and the Secretary of Health, Education, and Welfare, to the maximum extent possible, to attempt to coordinate the professional standards review program carried out under part B of title XI of the Social Security Act and comparable programs carried out by the Department of Medicine and Surgery to assess the quality of patient care in VA health care facilities. The Chief Medical Director would be required to report annually to the Congress on the effectiveness of such coordination.

New section 5059 would require the Chief Medical Director, through the Administrator, to report to the Congress not later than 3 months after the end of each fiscal year, on all activities in which the Chief Medical Director represents the VA as required by statute or otherwise, in an advisory or coordinating capacity with respect to programs carried out by other departments or agencies of the executive branch.

Subsection (f) of section 121 of the bill would make conforming changes to the table of sections at the beginning of chapter 81 of title 38.

This section of the bill would require coordination of the Professional Standards Review Organization (PSRO) program with the VA Health Services Review Organization (HSRO), established in all VA health care facilities in 1974, to the maximum extent practicable. The bill specifically would require sharing of information regarding norms of health care services, and, joint membership on PSRO and HSRO entities.

At this time we do not believe that it is desirable to mandate the degree of formal coordination between the PSRO and HSRO programs that appears to be required by the bill. The Administration fully supports the PSRO and HSRO concept of health services review that includes peer review based on objective norms, criteria, and standards. At this time, the PSRO system has an enormous task of developing the capability to review the care provided under the Medicare, Medicaid, and Maternal and Child Health programs. The addition of still further responsibilities now would not be consistent with maximum effectiveness in accomplishing these objectives.

The Administration also believes it is desirable to permit flexibility in medical care review systems in order to assist in identifying the most promising review methods and procedures. For this reason, the Administration's recent "Financial Assistance for Health Care Act" proposal required States to "provide for a system to assure the quality and proper utilization of services within the health services program of the State, including peer review of those services based on objective norms, criteria, and standards" Use of the PSRO system, per se, was not required. In our view, the same approach should also prevail at this time with respect to the VA medical system.

The VA will undertake coordination with the PSRO program to the extent that doing so would clearly contribute to the effectiveness of the PSRO program or to the accomplishment of VA objectives. Given that both of these activities are still in the early development and implementation stages, we recommend that the matter of formal coordination requirements between PSRO and HSRO should be deferred now and reviewed again within several years.

The report which would be required by the proposed section 5059 would be exceedingly difficult to prepare in any meaningful manner. There is a great deal of coordination required on a continuing basis with respect to programs carried out by other departments, agencies, or instrumentalities of the executive branch. To maintain even minimal records required for such a report we would require additional staff within the central office. In our opinion this would not effectively contribute to accomplishment of the DM&S mission and we strongly recommend that this requirement be eliminated from S. 2908.

Section 122 of the bill would amend chapter 82 of title 38 as follows:

Clause (1) would redesignate subsections (e) and (f) of section 5070 of title 38 as subsections (f) and (g) and insert in such section 5070 a new subsection (e) to provide that the exception to the normal 3-year leasing authority currently applicable to leases made for the purpose of subchapter I of chapter 82, be extended to the provisions of subchapter II and III of that chapter. As a part of a program of assistance to States for the establishment of new medical schools, subchapter I of Public Law 92-541 authorized the VA to lease lands and buildings under its control to grantee institutions. By a special exception contained in section 5073(a) such leases executed under subchapter I are not limited to the normal 3-year period. This proposed amendment would extend that provision to apply to the provisions of the other subchapters in chapter 82, thus permitting the making of long-term leases to existing medical and other health professions schools with which VA

medical facilities are affiliated, as a part of the assistance that may be provided under these authorities.

Under current law State governments (on behalf of State universities) as well as Boards of Directors (on behalf of private institutions) are understandably reluctant to enter into construction projects under a lease limited to 3 years, shorter even than the term of the grant itself. It seems apparent that the reasons for waiving the 3-year limit for purposes of subchapter I are equally applicable in regard to the purposes of subchapter II.

The construction of educational facilities at VA hospital sites, is an important aspect of the assistance required by established medical schools which are using these grants to expand their VA affiliations to include hospitals which are distant from the medical center and which are entering into formal educational programs for the first time. These include Fresno VA hospital which will become an affiliate of the University of California; San Francisco Medical School; Downey VA hospital in affiliation with Chicago Medical School; and Fargo and Sioux Falls VA hospitals in affiliation with the medical schools of North and South Dakota, respectively.

In these situations, and others which are presently under consideration, the existence of a modest educational facility for faculty, medical and other health professions students, and medical house staff will greatly enhance the health services programs of the hospitals without major incursions into the space in the hospital itself. The proposed legislation will greatly facilitate the effort by providing the long-range leasing authority that is essential to the success of the needed construction projects.

Clause (2) of section 122 of the bill would insert a new subsection (h) at the end of section 5070 of title 38 which would require the Administrator to report to the Congress within 90 days after the end of each fiscal year on the activities carried out under chapter 82 of title 38, including specific aspects of the program such as (1) an appraisal of the effectiveness of the programs, (2) the contributions of such programs in improving health care personnel under title 38, (3) a list of approved but unfunded projects, and amounts needed for each, and (4) recommendations for improvement of programs.

Clause (3) of section 122 of the bill would strike out paragraph (1) of section 5073(a) of title 38, and redesignate paragraphs (2) and (3) as paragraphs (1) and (2) respectively. As a technical matter, the reference to paragraph (1) in the current paragraph (2) (redesignated as paragraph (1) by the bill) should be deleted and a reference to new subsection (e) of section 5070 inserted in lieu thereof at each place it appears.

Clause (4) would strike out in section 5083(a) "subchapter IV of chapter 81 of". The purpose of this amendment is to clarify the identification of the existence of an affiliation agreement between a medical school and the VA, for the purposes of providing assistance under subchapter II of chapter 82 of title 38. This subchapter authorizes the making of grants to medical schools affiliated with the VA in order to expand and improve their training capacities. An eligible medical school is defined as one which is affiliated with the Veterans' Administration under an agreement entered into pursuant to sub-

chapter IV of chapter 81 of title 38, i.e., with respect to the sharing of medical facilities, equipment, and information. The proposed amendment would define the relationship as the type of educational affiliation originated by the VA in 1946 with the issuance of Policy Memorandum No. 2, and characterized by the appointment of a dean's committee as required by section 4112(b) of title 38.

Enactment of this section would not have any cost impact on the programs carried out under chapter 82 of title 38.

We would favor the enactment of section 122 of the bill.

Section 123 of the bill in subsection (a) would require the Chief Medical Director to carry out or provide for a study to determine the short-range and long-range direction of the hospital and medical program carried out under title 38 with reference to the increasing average age of the eligible veteran population.

The result of the study would be furnished the appropriate committees of Congress by the Chief Medical Director through the Administrator, not later than 12 months after the date of enactment of this Act. The report would include, but not be limited to, specific plans for—

- (1) increasing the number of all types of VA care beds;
- (2) increasing nursing home care (including intermediate and personal care) in community facilities;
- (3) emphasizing training for health care of elderly persons;
- (4) expanding alternatives to institutional care;
- (5) emphasizing treatment programs to meet the health care needs of an aging population;
- (6) meeting the special architectural, transportation, and environmental needs of an aging population; and
- (7) conducting biomedical and health services research designed to solve geriatric care problems.

The VA is opposed to this proposed amendment. We have authority to conduct studies of this nature and the areas for study proposed here are now being studied on a continuing basis. The proposed amendment to title 38 is unnecessary, and would duplicate effort and incur additional cost.

If this proposed amendment is enacted, the specific plans numbered (1) and (2) should be amended to say "adjusting" rather than "increasing" the number of beds, and at the end of numbers (1) and (2) should be added "based upon projected needs". This change in wording is warranted because it may be determined that not all of the types of care now available will need to be "increased". As a technical matter, section 123(a)(2) contains reference to "personal care" although no other reference to it is contained in this bill as introduced.

Subsection (b) of section 123 of the bill requires the Administrator to take appropriate steps, not later than 90 days after the date of enactment, to ensure that, to the maximum extent feasible, each individual eligible for new or expanded care and services as a result of the amendments made by this Act, be personally notified about them and copies of such notifications be furnished to the appropriate committees of the Senate and House and a description of how such forms were distributed.

TITLE II—VETERANS DRUG AND ALCOHOL TREATMENT AND REHABILITATION AMENDMENTS

Section 201 of the bill provides that this title may be cited as the "Veterans Drug and Alcohol Treatment and Rehabilitation Act of 1976."

Section 202 of the bill would amend paragraph (1) of section 601 of title 38, which defines the term "disability" for purposes of chapter 17 (hospital, domiciliary, and medical care) of title 38, to include alcoholism and drug dependence within the meaning of "disease".

Section 203 of the bill would amend subchapter II of chapter 17 of title 38, by adding a new section 620A (treatment and rehabilitation for alcoholism).

Subsection (a) of the new section 620A states a congressional finding and declaration of the seriousness of alcoholism and alcohol abuse in the Nation, including among the veteran population.

Subsection (b) of the new section of title 38 directs the Administrator to carry out specialized medical programs providing inpatient and outpatient treatment and rehabilitative services on a nationwide basis to veterans eligible for chapter 17 medical care who are suffering from alcoholism or alcohol abuse. The Administrator is further directed to stress the use in such program of recovered alcoholic counselors and half-way houses, encounter-style therapeutic communities and other treatment modalities—in a comprehensive program ranging from detoxification to recovery. Finally, subsection (c) of the new section requires an annual report as a part of the report submitted pursuant to section 214 of title 38, regarding the specialized programs carried out under this section and section 667.

We believe the authority which would be provided by this provision is unnecessary, in that we already have sufficient authority to meet the needs of those veterans who submit themselves for VA medical care with an alcohol abuse or alcoholism condition. Furthermore, where there are other facilities in the community which seem desirable to the veteran, we take every means possible to refer him to such facility and to assist him in obtaining all the care that can be provided to him. We also make full utilization of our domiciliary facilities, where the veteran needs sheltered environment for a while before he is ready for an alcohol free re-entry into society. We, therefore, do not favor these provisions of the bill.

Not only do we not believe this authority is necessary, but there are several provisions which we find to be highly objectionable. For example, we do not believe that particular stress should be placed on the encounter style therapeutic treatment modality and, in fact, have substantial doubt about the value of encounter style treatment within the VA. Furthermore, we believe there should not be more liberal contracting authority for alcoholism treatment than there is for other treatment.

We do not believe an annual report to the Congress on the nature and extent, and as known, the effectiveness of treatment and rehabilitation is necessary.

We strongly object to the use of the word "disability" throughout this section. The use of the word "disability" has the potential effect

of official Federal acceptance of alcohol abuse or alcoholism as disabling. The state of current knowledge does not settle the question of whether or not alcohol abuse and alcoholism are disabling medical conditions within the general framework of VA considerations and practices. The commitment to a major new funding requirement for disability pay for such a widespread condition should not anticipate the field of knowledge.

Section 204(a) of the bill would amend chapter 17 of title 38 by inserting a new subchapter VII—(special medical treatment and rehabilitative services for drug dependence or drug abuse disabilities).

New section 661 would define "veteran" so as to permit the furnishing of hospital care and medical services for a drug dependence or drug abuse disability to a person, not otherwise barred by the provisions of 38 U.S.C. 3103, who has a discharge or release which is "other than a dishonorable discharge". Under the present general definition of the term "veteran" contained in 38 U.S.C. 101(2), which is applicable to the chapter 17 benefits, the person must have a discharge or release which is "under conditions other than dishonorable." The change in language would effect a liberalization in that all persons with "other than honorable" or "bad conduct" discharges (other than those resulting from General Courts Martial) would automatically be eligible for treatment for a drug dependence or drug abuse disability.

New section 662 sets forth the basic provisions governing the provision of treatment and rehabilitative services for veterans suffering from one of the drug disabilities.

Subsection (a) directs the Administrator to furnish any veteran suffering from one of the drug disabilities with such special medical treatment and rehabilitative services or hospital and domiciliary care as he finds reasonably necessary to effect the veteran's recovery and rehabilitation.

Subsection (b) specifies that treatment and rehabilitative services under the new subchapter shall include, but not be limited to, in addition to those services pursuant to section 601 of this title, individual counseling and referral services, and crises intervention. It also specifies that such treatment and services shall be made available in VA directly administered hospitals, domiciliary facilities, and outpatient clinics as well as halfway houses and other community-based facilities, and in non-VA public or private facilities under contract with the Administrator.

Subsection (c) directs the Administrator to offer alternative modalities of treatment to each such veteran receiving treatment and rehabilitative services under the new subchapter (whether in VA or contract facilities) and specifies that the alternatives offered shall be based upon the individual needs of each such veteran.

Subsection (d) directs the Administrator to contract for treatment and services under the new subchapter to give the greatest feasible priority to community-based, multiple-modality programs employing peer group veterans and to include in such contractual arrangements the carrying out of maximum outreach efforts to identify and counsel veterans eligible under the new subchapter.

Subsection (e) directs the Administrator upon receiving an application for treatment and services under the new subchapter from a

veteran with an other than honorable or general discharge to (1) advise him of his right to apply to the appropriate military service to obtain a review of the nature of his discharge with a view toward removing any bar to eligibility for the receipt of veterans benefits under title 38; (2) advise him of the current military policy regarding a review of discharges received in connection with drug abuse offenses; and (3) advise him of all programs under title 38 and any other law to which he is or would be entitled if he had a general or honorable discharge. The subsection also directs the Administrator to offer, and, if requested, to provide any veteran within the provisions of the new subsection all appropriate assistance needed to facilitate the process of preparing and filing with the military an application for a review of the nature of his discharge.

Subsection (f) in paragraph (1) directs the Administrator to provide (either in VA-directly administered facilities or programs or those under contract with him) for treatment and services in the case of certain veterans eligible under the new subchapter who are involved in criminal proceedings for a veteran under criminal charge or conviction who is not confined and who is not required to participate in a treatment and rehabilitation program by any court of competent jurisdiction.

Paragraph (2) authorizes the Administrator to provide (either in VA-directly administered facilities or programs or those under contract with him) for treatment and services to any veteran under the new subchapter who has been criminally charged or convicted and who is required to participate in a treatment and rehabilitation program by a court of competent jurisdiction, but only under such conditions as the Administrator determines, on a case-by-case basis, will ensure that the veteran's participation in the particular program will not impair the voluntary nature of the services provided other patients in such program.

New section 663 in subsection (a) directs the Administrator to utilize all available VA resources to seek out and counsel toward treatment and rehabilitation all veterans eligible under the new subchapter, especially those with service after August 4, 1964.

Subsection (b) directs the Administrator to carry out an affirmative action program, in consultation with the Secretary of Labor and the Chairman of the Civil Service Commission, to (1) urge all Federal agencies, private firms and groups and persons to provide training opportunities for veterans provided treatment and services under this subchapter who are determined to be employable, and (2) provide all possible assistance to the Secretary of Labor in placing such veterans in such opportunities.

New section 664 in subsection (a) establishes the right of the Comptroller General of the United States, for the purposes of audit, to access to all books, records, documents, things or property of non-VA facilities carrying out treatment or rehabilitation programs under the new subchapter.

Subsection (b) directs the Comptroller General to carry out his audit responsibilities so as to comply with the provisions set forth in section 4132 of this title.

New section 665 requires a line item in the President's annual budget submission showing the estimated VA expenditures under the new subchapter.

New section 666 establishes procedures and requirements regarding the transfer, and treatment therein, of active-duty servicemen to VA medical facilities in connection with a drug disability.

Subsection (a) provides for the transfer of an active-duty serviceman with a drug disability to a VA medical facility for treatment pursuant to mutually agreed upon terms between the Secretary of the military department concerned and the Administrator and subject to reimbursement by such service. Such transfers are authorized only within the last 90 days of a tour of duty. After such a transfer, a serviceman would receive treatment and rehabilitative services on the same terms and conditions as prescribed for a veteran in the new subchapter.

Subsection (b) requires the Administrator to report periodically to the Secretary concerned regarding the progress of the treatment of each serviceman transferred and to release such serviceman back to the Secretary concerned when the Administrator finds that the disability is stabilized or certifies that the member is refusing to comply with reasonable terms and conditions of treatment or that treatment would otherwise no longer be beneficial to such serviceman.

Subsection (c) prohibits transfers under new section 657 unless the serviceman in question specifically requests transfer for a specified period of time within his remaining tour of duty and does so in writing and further prohibits the extension of such treatment beyond such specified period of time unless the serviceman specifically requests a specified extension and such request is approved by the Secretary and the Administrator.

New section 667 requires the Administrator to submit to the Congress 6 months after enactment and thereafter on each September 1 a report on the implementation of the new subchapter and new section 620A (regarding alcoholism treatment and rehabilitation) added by the bill, broken down separately with respect to alcoholism and drug abuse disabilities, and an evaluation of the effective alternate treatment and rehabilitation modalities provided under the new subchapter and under new section 620A. The report will also include (1) numbers of patients treated, (2) average duration of treatment, (3) estimates of successful rehabilitation and recovery, (4) an analysis of rehabilitation experience, (5) a description of outreach and employment efforts, (6) a full accounting of payments to non-VA facilities and an evaluation of services provided therein, (7) experience under the medical confidentiality provisions, (8) new program plans, and (9) any legislative recommendations.

Subsection (b) of section 204 of the bill amends the table of sections at the beginning of chapter 17 of title 38 to reflect the addition of the new subchapter added by subsection (a) of section 204.

Generally speaking, we believe the authority which would be provided by this new provision is unnecessary, in that we now have sufficient authority to meet the needs of those veterans who submit themselves for VA medical care with a drug dependence or drug abuse

condition. Furthermore, in those instances where there are facilities in the community which seem desirable to the veteran, we take every means possible to refer him to such facility, and to assist him in obtaining all the care that can be provided to him. Where the veteran needs a sheltered environment for a time before his drug-free re-entry into society, we can either provide that type of environment in our domiciliary facilities, or refer him to one of the recently expanded federally funded drug abuse treatment slots in the private community. Moreover, we cannot support a more liberal treatment of veterans with a drug abuse condition than would be provided to veterans for any other medical condition. Accordingly, we do not favor the enactment of this proposal.

In addition to the general comments made above in opposition to this provision, there are a number of more specific comments which should be made.

The very title of this new subchapter has the potential effect of official Federal acceptance of drug dependence and drug abuse as disabling. The state of current knowledge does not settle the question of whether or not drug dependence and drug abuse are disabling medical conditions within the general framework of VA considerations and practices. The term "dependence" has been broadened in recent years to include psychological dependence and the list of drugs which have potential for abuse is everlengthening. We strongly recommend deletion of the word "disability" throughout and substitution of the word "condition" if the bill is to be given further consideration.

We cannot support, for the reasons indicated earlier in this report, any change in the nature of discharge eligibility which would be provided by the new section 661. We believe VA medical care should be premised upon good service, and we certainly cannot support setting out the veteran with the drug abuse problem for special consideration and eligibility for medical care to the exclusion of veterans with other disabilities. Furthermore, this would require an unwise fragmentation of eligibility for VA benefits in that an individual with a bad discharge might be eligible for drug abuse treatment but for no other benefits. This would result in confusion and increased pressures to make other benefits available. In fact, a number of the benefits such as vocational counseling and training, are important elements in our comprehensive strategy against drug abuse. The proposal would, therefore, be difficult to implement.

The stipulation that treatment be provided for a veteran who has been charged with, or convicted of a criminal offense by any court, who is not confined and who is not required to participate in the treatment and rehabilitation program by any such court is unnecessary. We recommend its deletion since currently the VA is providing such treatment for all eligible veterans who are considered treatable. Our policy has been since December 1, 1972 (M-1, part 1, chapter 4, change 3) that "a veteran in the custody of civil authorities or under criminal charges does not forfeit any right he may have to hospital or domiciliary care by the VA. He must, however, be in a position to accept hospital or domiciliary care if it is offered to him. Charges will have to be dropped and/or the veteran paroled or released unconditionally to the VA. If the veteran is paroled by the court, he may be accepted only if there is

no obligation to return him to custody of civil authorities. This does not preclude advising the civil authorities of the expected date of discharge when requested." We would, however, support the section that would permit the VA to assist veterans with a drug abuse condition who were, by court direction, in need of a treatment and rehabilitation program.

In reference to treatment of members of the Armed Forces by the VA, we reiterate our concern expressed earlier that "disability" findings in drug dependence or drug abuse cases would quickly become indistinguishable from any other medical disease justifying compensation.

The implication that active duty personnel would be transferred to VA facilities and treated for appreciable periods while on active duty raises serious questions about the effect on treatment outcome of such a structure. To increase the likelihood of success, treatment should be provided as early as possible, as close to the location where difficulty such as problem behavior is being observed or reported, and with the assumption that the problem will be resolved and the individual will be reintegrated into his or her already established community membership. These desired conditions are not met within the proposal as structured. They are currently being met by the treatment and rehabilitation programs administered directly by the Department of Defense.

We recommend that the present existing agreement between the Veterans' Administration and the Department of Defense regarding the transfer of active duty drug dependent servicemen to the VA be continued. This policy provides for a minimum of 30 days residential treatment for the condition. The drug dependent serviceman who is approaching his expiration of term of service date and has insufficient time for service rehabilitation will be processed for discharge and transferred to the VA for treatment with separation effective 15 days or more subsequent to arrival. This 15-day minimum requirement may be waived when it is determined to be in the best interest of the patient and it is agreeable with the receiving VA facility.

Section 663 is unnecessary because the VA has already demonstrated considerable initiative in this direction. The Department of Medicine and Surgery has assigned 139 persons as outreach rehabilitation technicians (36), veterans assistance counselors (65), and community services specialists (38) to its drug dependence treatment programs for just such purposes as outlined in this section.

We do not support the provision requiring the Administrator to make an annual report to the Congress, but should such a report be required, for the reasons stated above in reference to the alcoholism program, we do not believe that reports should be prepared separately.

For all of the above reasons, we do not support this provision.

It is estimated that the annual costs to implement title II of the bill would be as follows:

Transition quarter.....	\$338, 000
1st year.....	11, 511, 000
2d year.....	6, 245, 000
3d year.....	6, 290, 000
4th year.....	6, 335, 000
5th year.....	6, 448, 000

TITLE III—MEDICAL TECHNICAL AND CONFORMING AMENDMENT

Section 301 would cite title III as the "Veterans Medical Technical and Conforming Amendments of 1976."

Section 302, in subsection (a), would amend the title of chapter 17 by inserting the words "NURSING HOME" in such title. This technical change is being made to reflect a benefit which is currently available.

Subsection (b)(1) of section 302 would amend section 601(5)(A) (as redesignated by section 102(1) of the bill) to delete the requirement that a Veterans' Administration facility be one over which the Administrator has exclusive jurisdiction. The reference to the exclusive jurisdiction of the Administrator was made obsolete by the addition of section 5007 to title 38, by Public Law 93-82. Much Veterans' Administration property is now within the concurrent jurisdiction of local authorities.

Subsections (b)(2) and (3) of section 302 of the bill would amend the definition of VA facilities contained in section 601(4) of title 38, to include additional authority to contract for private facilities. Specifically, subclause (2) would provide contract authority for hospital care or medical services for any of the categories of individuals now listed in section 601(4)(C), when facilities under the jurisdiction of the Administrator, or other Government facilities, are not geographically accessible or capable of furnishing the care or services required. Subclause (3) would provide contract authority (hospital care or medical services) to treat any disability of a veteran being treated on a post VA hospital basis, or being treated for a service-connected disability rated at 50 percent or more, as well as authority to contract for private hospital care for *any* disability of a veteran where the VA is not capable of furnishing the required care.

This provision appears to be intended to provide authority to handle the needs of certain patients by contract, in the light of changes proposed elsewhere in this bill which directs that most VA care, particularly for the non-service-connected, must in the future be provided in VA facilities. For example, there is now no requirement in subsections 612(f) and (g) of title 38, that the medical services authorized by those sections be furnished in VA facilities. One of the provisions of this bill would make such a requirement. It is also apparently intended to provide statutory authority for certain types of cases where we have veterans being treated in our facilities, but because of some special emergency needs which we cannot meet, we are forced, for humanitarian reasons, to obtain the needed care from private facilities, even though the veteran may be non-service-connected.

As indicated earlier, we feel there is merit in directing that care be provided, to the extent possible, in VA-operated facilities, but realize there are situations where private facilities must be obtained on a contractual basis, if we are to meet our medical care obligation. However, while the intent of this provision, with the accompanying requirement that care be provided in VA facilities, may have been to emphasize our special obligation to the service-connected veteran, the way it is now drafted, it would provide an extension in our contract

authority applicable to the non-service-connected veteran, which we do not believe is wise. For example, it would provide authority to contract for inpatient care for non-service-connected veterans any time it is determined that VA facilities are not capable of furnishing such services or are geographically inaccessible.

Furthermore, this contracting authority would not be limited to emergency situations, nor to situations where it is more economical to use private outpatient facilities because of the geographic inaccessibility of VA or other federally operated facilities. Moreover, there is some duplication in the authority which would be provided by the two new clauses. Clause (3) also has a technical deficiency, in that it would seem to authorize contracting for hospital care under section 612 of title 38, even though the section is limited to the provision of outpatient care.

We believe the basic purpose of this change can be better accomplished by amending 38 U.S.C. 610(4) to read as follows:

"The term 'Veterans' Administration facilities' means—

(A) facilities over which the Administrator has direct jurisdiction;

(B) Government facilities for which the Administrator contracts;

(C) private facilities for which the Administrator contracts (when facilities described in clause (A) or (B) of this paragraph are not (i) economical because of geographic inaccessibility or (ii) capable of furnishing the care or service required) in order to provide (a) hospital care or medical services to a veteran for the treatment of a service-connected disability, or a disability for which a veteran was discharged or released from the active military, naval, or air service; (b) medical services for any disability described in clause (1)(B) or (2) of section 612(f) of this title; (c) hospital care in emergency situations for a patient admitted to a VA facility, as described in clause (A) or (B) of this paragraph; (d) hospital care for women veterans; (e) hospital care for veterans in a State, territory, Commonwealth, or possession of the United States not contiguous to the forty-eight contiguous States, except that the annually determined average hospital patient load per thousand veteran population hospitalized at Veterans' Administration expense in Government and private facilities in each such noncontiguous State may not exceed the average patient load per thousand veteran population hospitalized by the Veterans' Administration within the forty-eight contiguous States . . ."

These changes would continue our present contracting authority for outpatient care, in certain limited situations, for non-service-connected veterans in post-hospital situations or who have a disability rated at 80 percent, or more. This authority could only be used when our present facilities are not capable of furnishing the needed care, or the use of such private care would be more economical because of the geographical inaccessibility of VA or other government-operated facilities. It would also provide a statutory basis for the long-standing assumption that once we assume responsibility for the VA hospital care of a patient, it is our obligation to ensure that the care the patient

needs is available, even if it means contracting, in an emergency, with a private medical care facility. This provision specifically authorizes this humanitarian approach. Of course, if there is no emergency, the patient is transferred to the nearest VA facility capable of providing the needed treatment.

We could not support the section as introduced, but can support it if amended as we have suggested.

Subsection (c) of section 302 would amend the title of subchapter II of chapter 17 by inserting the words "Nursing Home" in such title. This technical change is being made to reflect a benefit which is currently available.

Subsection (d) (1) of section 302 would amend the title of section 610 by inserting the words "nursing home." This technical change is being made to reflect a benefit which is currently available.

Subsection (d) (2) of section 302 would amend subsection (a) (1) (B) of section 610 by inserting the words "nursing home." This technical change is also being made to reflect a benefit which is currently available.

Subsection (d) (3) of section 302 would amend section 610(d) to remove the requirement that nursing home care be furnished in a hospital under the exclusive jurisdiction of the Administrator. As mentioned previously, this amendment is necessary since much VA property is now operated under concurrent jurisdiction.

Subsection (e) of section 302 would amend section 610(b) (2) to remove the requirement that a veteran, in order to receive Veterans' Administration domiciliary care, be a veteran of a war or of service after January 31, 1955. This would have the effect of opening VA domiciliaries to the peacetime veteran, and would be contrary to the purpose for which they were intended, i.e., to provide living quarters for certain wartime veterans. We oppose this change.

Subsection (f) (1) of section 302 would amend the title of section 611 to permit the Administrator to furnish care, by VA personnel, during examinations and in emergencies rather than just hospitalization.

Subsection (f) (2) of section 302 would amend section 611(b) to permit the Administrator to furnish medical services as a humanitarian service in emergencies. The present 611(b) only provides for furnishing hospital care in such cases.

Emergency cases requiring only outpatient care, as in the case of a deep wound requiring immediate attention without hospital admission, or a community disaster, would be covered by this new authority. Since needed care obviously cannot be refused in an emergency situation, the amendment would merely provide the technical authority which was inadvertently not provided when the present emergency humanitarian treatment language was enacted. We favor this amendment. Since it would provide for reimbursement for the services rendered, there would be no cost associated with this proposal.

Subsection (g) (1) of section 302 would correct a technical error in section 612(e) with reference to veterans of Indian Wars. Section 611(e) currently uses the term "Indian wars". This amendment merely replaces the lower case "wars" with the grammatically correct upper case "Wars".

Subsection (g) (2) of section 302 would amend section 612(f) (1) (B) to change the term "granted hospital care" to "furnished hospital care".

Subsection (g) (3) of section 302 would amend section 612(g) to require that veterans described therein only be furnished medical services within the limits of Veterans' Administration facilities. We favor this amendment since it is consistent with the pattern adopted earlier in the bill to limit VA care to what can be provided in VA facilities, with such term defined so as to allow us to meet the basic medical care needs of eligible veterans, with special emphasis on the service-connected veteran.

Subsection (h) of section 302 would substitute the term "Office of Management and Budget" for the term "Bureau of the Budget" in section 616. The Bureau of the Budget was redesignated the Office of Management and Budget by Reorganization Plan No. 2 of 1970. This change reflects the redesignation.

Subsection (i) of section 302 would amend the title of subchapter III of chapter 17 by inserting the words "Nursing Home" in such title. This technical change is being made to reflect a benefit which is currently available.

Subsection (j) of section 302 would amend clauses (1) through (3) of section 621. This section currently permits the Administrator to prescribe rules and regulations governing the furnishing of hospital and domiciliary care. The addition of nursing home care merely reflects a benefit which is currently available.

Subsection (k) of section 302 would amend subsection (a) of section 622. This section pertains to the statement under oath of an applicant of inability to defray necessary expenses. The reference in section 622 to "section 610(a) (1)" would be changed to "section 610 (a) (1) (B)", and the reference to "section 632(b)" would be changed to "section 632(a) (2)". The current reference to section 610(a) (1) would require a statement of inability to defray expenses from both veterans with a service-connected and non-service-connected condition. The current reference to section 632(b) relates to payments to the Republic of the Philippines rather than to the care and treatment of veterans with a non-service-connected disability.

These technical changes, though necessitated by the passage of Public Law 93-82, were inadvertently omitted at that time. This amendment will correct the oversight. These technical changes are being made to accurately cite the various subsections referred to.

Subsection (l) of section 302 would amend section 624(c) to remove the requirement that a veteran be a veteran of any war to receive hospital care in the Philippines for any non-service-connected disability. We do not favor this change.

Subsection (m) of section 302 would amend section 627 by striking out "1958" and inserting "1957". That section is a savings provision which was intended to preserve entitlement to certain VA benefits of certain individuals who met service requirements under law prior to the codification of title 38, United States Code, but would fail to meet those requirements on the effective date of that codification. Those laws were codified by Public Law 85-56, which carried an effective date of January 1, 1958. Therefore, the savings clause should have

preserved that entitlement as of the day before the effective date, which would have been on December 31, 1957. This amendment would correct that error.

Subsection (n) of section 302 would amend subsection (a)(1) of section 628 to correct a grammatical error. Section 628, added by Public Law 93-82, provides, in pertinent part "where such care and services were rendered in a medical emergency of such nature that they would have been hazardous to life or health." The word "they" should be changed to read "delay". This amendment effects the change.

Subsection (o) of section 302 would amend section 641 to delete the requirement that a veteran be a veteran of a war or of service after January 31, 1955, to receive care in a State home. We do not favor this liberalization.

Subsection (p) of section 302 would amend section 643 to delete the requirement that a veteran be a veteran of a war in order for a State home to receive payment for his care. We do not favor this liberalization.

Subsection (a) of section 303 would amend the table of chapters and parts at the beginning of title 38 and the table of chapters at the beginning of part II of such title to insert the words "Nursing Home." This technical change is also being made to reflect a benefit which is currently available.

Subsection (b) of section 303 would amend the table of sections at the beginning of chapter 17 by inserting the words "Nursing Home" in the title of subchapter II, the title of section 610, and title of subchapter III. This technical change is also being made to reflect a benefit which is currently available.

Subsection (b) of section 303 would also amend the title of section 611 to substitute "Care" for "Hospitalization" during examinations and in emergencies.

Section 304 would amend section 903(a) to permit the payment of burial costs and necessary transportation of the body when a veteran dies in a Veterans' Administration facility to which he was properly admitted for nursing home care under section 610 or 611(a).

Under current law, such expenses are authorized for individuals who die while receiving VA hospital or domiciliary care. Though Public Law 93-82 sought to equalize eligibility for care in VA hospitals, domiciliaries, and nursing care facilities, it inadvertently omitted the extension of this burial benefit to VA nursing home beneficiaries. We support the amendment. Costs to the VA would be minimal.

Subsection (a)(1) of section 305 would amend section 4101(a) to describe, in such subsection, the primary function of the Department of Medicine and Surgery as being one to provide a complete medical and hospital service for the medical care and treatment of veterans.

Subsection (a)(2) of section 305 would amend section 4101(b) to delete the above phrase.

Subsection (a)(3) would further amend section 4101 by inserting a new subsection (c).

Subsection (c)(1) of section 4101 would direct the Administrator to carry out a program of medical research, including biomedical, prosthetic, and health care services research, and stressing research into spinal cord injuries and diseases and other disabilities that lead to paralysis of the lower extremities.

The proposed change in 38 U.S.C. 4101(c) (1) contained in section 305(a) (3) beginning with, "including biomedical, . . ." and ending with "of the lower extremities" is unnecessary and the last 20 words beginning with, "and stressing research . . ." is purely directive. We do not favor specific mandates to pursue research in limited scientific areas because they tend to be unprofitable.

Subsection (c) (2) of section 4101 would define prosthetic research as including research and testing in the field of prosthetic, orthotic, and orthopedic appliances and sensory devices and would direct the Administrator to make the results of such research available to any person, and to consult with the Secretary of Health, Education, and Welfare and the Commissioner of the Rehabilitation Services Administration, Department of Health, Education, and Welfare, in connection with programs administered by them.

Subsections (c) (3) (A) through (H) of section 4101 would authorize the Administrator to provide, in a contract for research which involves a risk of an unusually hazardous nature, that the United States will indemnify the contractor against certain types of liability to third persons or loss of or damage to property of the contractor. Subsection (c) (3) also provides controls over and provisions for such payment.

The proposed change in sections 305(c) (2) and (3) removing the "no-year" status of prosthetics research funding is a substantive change to title 38, although it is contained in the technical and conforming comments section (title III). We do not favor "annualizing" prosthetics research funds. This action is unwarranted and unwise and would remove the fiscal flexibility necessary to conduct a small but complex research program.

Subsections (b) and (c) of section 305 are technical in nature and would reflect in the heading of section, subsections, and the table of sections the prior amendments with respect to research and development and indemnification of contractors.

The proposed change contained in section 305(c) (2) which adds to the language of 38 U.S.C. 216(a) (2) is not necessary or desirable. The required consultation and cooperation with HEW is already very active and the new language imposes little added burden. It does, however, stipulate rather narrowly the direction of cooperation and coordination and limits such actions to HEW. The substitution of a general phrase would be better and could read "and shall consult and cooperate with other Federal agencies to this end."

Subsection (d) (1) of section 305 would amend sections 4103(a) (2) and (3) to clarify the current practice that the appointment of the Deputy Chief and Associate Deputy Chief Medical Directors is made by the Administrator "upon recommendation of the Chief Medical Director."

Subsection (d) (2) of section 305 would amend section 4103(a) (4) to correct a grammatical error.

Subsection (d) (3) of section 305 would amend section 4103(b) (3) to provide that any person whose appointment under section 4103 is extended would be subject to removal by the Administrator for cause. We favor this amendment since it would provide the Administrator with additional flexibility. The Administrator's current authority to remove for cause is limited to persons appointed or reappointed.

Subsection (d) (4) of section 305 would amend section 4103(c) to authorize the Administrator to redesignate a member of the Chaplain Service as Director, Chaplain Service, for any period not exceeding 2 years. Redesignations are currently for 2-year periods, as is the original designation. Clause (C) would clarify that redesignations could be made for periods of less than 2 years. We favor this subsection as it would give Administrator desirable flexibility not currently available.

Subsection (e) of section 305 would amend section 4105(a) (5) to provide that an optometrist must hold the degree of doctor of optometry from a school of optometry approved by the Administrator. We favor enactment of this subsection since it would provide consistency with the qualifications required of other Department of Medicine and Surgery appointees, such as physicians, dentists, nurses, and pharmacists.

Subsection (f) of section 305 would amend section 4108(b) by changing the significance of the reference to section 4112(b). Although an affiliation agreement is a prerequisite to the applicability of an advisory committee called for in section 4112(b), said section is not basic authority for the agreement itself. Therefore, the change from "pursuant to" to "as referred to in" more accurately describes the situation.

Subsection (g) of section 305 would amend section 4114(b) by amending paragraph (2) to define the term "intern" to include an internship or the equivalency thereof, as determined in accordance with regulations which the Administrator shall prescribe, and to define the term "intern" to mean a person serving an internship.

Subsection (a) of section 306 would amend section 5001(a) (2) to remove the requirement that the Administrator have exclusive jurisdiction over hospital facilities and to correct a grammatical error. The word "tuberculous" would be substituted for the word "tuberculosis," which is erroneous in the context used in the subsection. The pertinent portion of the subsection would then read "eligible veterans who are tuberculous".

Subsection (b) of section 306 would amend subchapter III of chapter 81 to remove the requirement, in several sections of the subchapter, that a veteran be a veteran of a war in order to receive nursing home care in a State home facility. As indicated previously, we do not favor this amendment.

Subsection (c) of section 306 would amend section 5053 to make technical clarifying changes.

Subsection (d) of section 306 would amend section 5054(b) to correct a grammatical error.

Subsection (e) of section 306 would amend section 5055(a) in order to reflect the current organization of the Department of Medicine and Surgery. When the Exchange of Medical Information program was enacted, the Assistant Chief Medical Director for Research and Education in Medicine was the official charged with the responsibility of administering the program. However, because of a subsequent reorganization in that Department, another official has been assigned that function. Therefore, the proposed amendment would give sufficient flexibility in the law to assure the attendance of an appropriate Assist-

ant Chief Medical Director charged with responsibility over the program at meetings of the Advisory Subcommittee of the Special Medical Advisory Group.

Section 307 would amend section 5083(a) to delete the reference to any medical school affiliated with the Veterans' Administration under an agreement entered into pursuant to subchapter IV of chapter 81 of this title. This would correct a technical error since subchapter IV of chapter 81 does not relate to the affiliation of a medical school with the VA, and the language as now used is meaningless. As a technical matter, it should be noted that this change duplicates a change made in title I of the bill. We favor the clarification.

Subsection (a) of section 308 would amend section 5202 to provide that the Administrator may dispose of the unclaimed personal property of a dependent or survivor of a veteran who dies while receiving care in a Veterans Administration medical facility. Through oversight, this section was not amended at the time of passage of Public Law 93-82, which authorized such care. We favor this provision.

Subsection (b) of section 308 would amend section 5220(a) to provide that the property of a dependent or survivor of a veteran who dies while receiving care in a Veterans' Administration medical facility shall vest in the United States if the deceased leaves no surviving heirs. Through oversight, this section was not amended at the time of passage of Public Law 93-82, which authorized such care. We favor this provision.

Subsection (c) of section 308 would amend section 5221 to provide that the fact of death of a dependent or survivor of a veteran who dies while receiving care in a Veterans' Administration medical facility, and leaves no surviving heirs, shall give rise to a conclusive presumption of a valid contract for the disposition of all property left by the decedent. Through oversight, this section was not amended at the time of passage of Public Law 93-82, which authorized such care.

Section 309, in referring to various subsections, would amend subchapter I of chapter 73 to make various language changes in addition to including, for purposes of sections and subsections of the subchapter, in addition to nurses, such other specialties as physicians' assistance and expanded-duty dental auxiliaries. These changes to the organization of the Department of Medicine and Surgery were necessitated by the passage of Public Law 94-123, the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975, which authorized the appointment of these additional personnel. We favor these changes.

Section 310 would make various gender changes in title 38, and we favor the changes.

Section 311 would provide that amendments made by the bill, with certain exceptions, would be effective thirty days after the first day of the first calendar month following the date of enactment of the bill.

As a technical matter since this bill changes the language "direct and exclusive jurisdiction" to "direct jurisdiction" in sections 601(4) (A), 610(d), and 5001(a) (3) of title 38, we suggest that consideration be given to making the same change in 620(a) (ii).

VETERANS ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., June 10, 1976.

HON. ALAN CRANSTON,
*Chairman, Subcommittee on Health and Hospitals, Committee on
Veterans' Affairs, U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: I regret that I was unable to appear before your subcommittee on Tuesday, May 25 when you were discussing the provisions of S. 2908. I was on the West Coast appearing at several meetings and testifying at an administrative hearing in a personnel matter.

Dr. Herbert Baganz and Dr. Paul Haber, who represented me at the meeting, have reviewed the content of the session with me and other members of the top staff. Among the items that were considered was the amendment which deals with the proposed inclusion of optometrists and podiatrists within title 38, United States Code, for employment and pay purposes. I take this opportunity to express myself on this subject in the hope that by doing so I can provide further information useful to your further deliberations on this matter.

The Department of Medicine and Surgery has traditionally supported the use of all levels of professional and allied health personnel as members of the health care delivery team utilized in providing care to our veteran beneficiaries. As the Committee knows, we have enthusiastically supported the development of nurse clinicians, nurse practitioners and physician assistants, plus a number of other specially trained personnel each of whom make important contributions to our objective. In line with this basic philosophy, the Department has been working toward the utilization of increased numbers of optometrists and podiatrists. Admittedly our progress has been slow and somewhat hampered by a salary structure for these two disciplines which we feel is noncompetitive. On the other hand, the GS-12 grade can be achieved, and we have used this grade within DM&S. This currently provides a salary spread of \$19,386 to \$25,200.

It is my personal conviction that we can be successful in efforts to resolve the salary problem administratively. I am equally convinced that by including these two valuable health professionals in title 38, we will jeopardize the basic provision as more employee groups are added to this unique and most important Veterans' Administration authority.

The basic principles which I have used in arriving at judgments and decisions which pertain to title 38 rely almost exclusively on the original concept which made the title 38 system an absolute necessity for the successful operation of the VA health care delivery system. These principles are based upon the need for certain health professionals to be available and responsive to the needs of patients without regard to the 40-hour basic workweek requirements associated with the relatively inflexible General Schedule system.

The framers of Public Law 293, 79th Congress, recognized this as a necessity and therefore provided the authority to employ physicians, dentists and nurses on the basis of availability for 24 hours a day, 7 days a week. Further, they made possible the selection of the individual and the linkage of the person to salary based upon professional qualifi-

cations and personal attainments, rather than linking the salary to a described job content.

Conversely, optometrists and podiatrists work within our system on a structured time-basis, providing care to veterans within a system of prearranged scheduled appointments. To my knowledge, there is not the requirement for emergency patient care needs to be met in either area of expertise. Therefore, the basic principles described above do not seem to apply to these two groups of employees.

Perhaps extraneous to the basic consideration, and yet of possible importance to individual optometrists and podiatrists, is the fact that if they were to be included in title 38, and were full-time within our system, they would be prohibited from engaging in outside "moonlight" activity. This is a common practice among pharmacists, psychologists, and others who are employed under the General Schedule and who can and do provide a useful service to the community, and at the same time supplement the normal Federal salary by working in a private practice or another institution. It is this opportunity which I believe has made our pharmacists and psychologists less than eager to be included in title 38. Perhaps the same consideration would apply to optometrists and podiatrists if they knew of this consequence.

Again, let me apologize for my non-availability at the time of your meeting, and assure you that we will continue to do all that we can to employ additional numbers of optometrists and podiatrists so that they may give the benefits of their experience and skills to our patients.

Sincerely,

JOHN D. CHASE, M.D.,
Chief Medical Director.

[No. 106]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., April 23, 1976.

HON. VANCE HARTKE,
*Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of February 4, 1976 for the views of this Office on S. 2908, a bill "To amend title 38, United States Code, to improve the quality of hospital care, medical services, and nursing home care in Veterans' Administration health care facilities; to require the availability of comprehensive treatment and rehabilitative services and programs for certain disabled veterans suffering from alcoholism, drug dependence, or alcohol or drug abuse disabilities; to make certain technical and conforming amendments; and for other purposes."

In its report of March 2, 1976, to your committee on S. 2908, the Veterans' Administration stated that it shared Senator Cranston's concerns about whether it is reasonable for the VA health care budget to continue to expand at the rapid rate achieved over the last 5 years, and whether VA could continue to provide increased care and services to more and more veterans without adversely affecting its ability to make the treatment of veterans' service connected disabilities its primary focus. For reasons discussed in its analysis of S. 2908, the VA concluded that it could not support the bill as introduced.

We concur with the views expressed in the report of the Veterans' Administration and, accordingly, recommend against enactment of S. 2908 unless modified as recommended by the VA.

Sincerely,

JAMES M. FREY,
Assistant Director for Legislative Reference.

[No. 32]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., August 28, 1975.

HON. VANCE HARTKE,

*Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 531, 94th Congress, a bill "To amend title 38, United States Code, to provide that the Administrator of Veterans' Affairs may furnish outpatient dental services and treatment for a non-service-connected disability to any war veteran who has a service-connected disability of 80 percent or more."

The subject bill would amend section 612(b) of title 38 to permit the furnishing of unrestricted outpatient dental service and treatment, and related dental appliances, to any veteran who has a service-connected disability rated at 80 percent, or more. Under present law, such a veteran is eligible for the indicated treatment only for a compensable, service-connected dental condition, or, if service-connected, but noncompensable, the treatment is limited to a one-time completion basis, and then only if application is made within one year after discharge. The proposal would remove all limitations for this class of veterans, and make them eligible for outpatient dental care and treatment for non-service-connected dental conditions as well as service-connected conditions which do not meet the criteria otherwise applicable.

It is obvious that enactment of the subject bill would result in significant costs to the Veterans' Administration, and must be considered in the context of the overall economic difficulties facing this Nation.

The President has recommended a series of actions to meet the Nation's energy problems. He pointed out that these proposals would result in a sizable budget deficit, approximately \$60 billion in fiscal year 1976. Accordingly, he called for a curb on the rate of increase in domestic programs that has occurred in recent years. We agree that, during this time when we are still experiencing considerable inflationary pressure, we must demonstrate restraint in handling proposals for increase in benefit programs.

In view of the foregoing, we are opposed to the enactment of S. 531.

Enactment of the subject bill would result in the following estimated costs to the Veterans' Administration:

Fiscal year:

1976	-----	\$5, 110, 000
1977	-----	5, 130, 000
1978	-----	4, 680, 000
1979	-----	1, 880, 000
1980	-----	1, 880, 000

Total, 5-year costs----- 18, 680, 000

We were advised by the Office of Management and Budget in regard to a report to the Chairman of the House Committee on Veterans' Affairs on H.R. 6087, 94th Congress, a bill with identical provisions to S. 531, that there was no objection to the presentation of that report from the standpoint of the Administration's program.

Sincerely,

A. J. SCHULTZ, JR.,
Associate Deputy Administrator
(In the absence of
Richard L. Roudebush, Administrator).

[No. 39]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., September 25, 1975.

HON. VANCE HARTKE,
*Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of February 10, 1975 for the views of this Office on S. 531, a bill "To amend title 38, United States Code, to provide that the Administrator of Veterans' Affairs may furnish outpatient dental services and treatment for a non-service-connected disability to any war veteran who has a service-connected disability of 80 percent or more."

In its report to your committee on S. 531, the Veterans' Administration explains its reasons for recommending against favorable action on the bill. We concur in the views expressed in the report of the Veterans' Administration and, accordingly, recommend against the enactment of S. 531.

Sincerely,

JAMES M. FREY,
*Assistant Director
for Legislative Reference.*

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., February 18, 1976.

HON. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs, U.S. Senate, Washington, D. C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 2771, 94th Congress, a bill "To amend title 38, United States Code, to provide special psychological readjustment therapy, counseling services, and followup treatment to veterans of the Vietnam era and their dependents who are in need of such assistance because of military service performed during the Vietnam era."

The subject bill would direct the Administrator to provide special psychological readjustment therapy and counseling services, and necessary followup services, to Vietnam era veterans and their dependents who are experiencing psychological problems. The bill would authorize the Administrator to contract for the necessary psychiatric, psychological, and counseling services from public or private sources if necessary or appropriate to the successful treatment of the veteran or dependent. A special out-reach program is mandated by the bill.

We are strongly opposed to enactment of the subject bill.

The bill is discriminatory in that it grants Vietnam era veterans and their dependents benefits that are not available to veterans of other wars.

Under the bill, the VA could contract, not only for a non-service-connected veteran, but also for his dependents. This would be a far-reaching extension of the present law which, with few exceptions, limits our authority to contract for private hospital care to those situations where the care is for persons suffering from service-connected disabilities. Such an extension, particularly with respect to dependent care, is not, in our opinion, warranted. The VA may now provide certain medical benefits to the wife or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability, and to the widow and child of a veteran who died as a result of a service-connected disability. However, it should be noted that such benefits may not be provided if the beneficiary is otherwise eligible for medical care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Finally, we oppose the enactment of S. 2771 because of its budgetary impact. We estimate the cost to the VA in implementing the bill would be approximately \$42,100,000 over the first 5 years. In view of the urgent need to restrain Federal spending, we believe this cost to be excessive.

Accordingly, we are opposed to the enactment of S. 2771.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely,

RICHARD L. ROUDEBUSH,
Administrator.

[No. 102]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., March 25, 1976.

HON. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of December 16, 1975, for the views of this Office on S. 2771, a bill "To amend title 38, United States Code, to provide special psychological readjustment therapy, counseling services, and followup treatment to veterans of the Vietnam era and their dependents who are in need of such assistance because of military service performed during the Vietnam era."

In its report to your Committee on S. 2771, the Veterans' Administration explains its reasons for recommending against favorable action on the bill. We concur in the views expressed in the report of the Veterans' Administration and, accordingly, recommend against the enactment of S. 2771.

Sincerely,

(Signed) James M. Frey
JAMES M. FREY,

Assistant Director for Legislative Reference.

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., February 18, 1976.

HON. VANCE HARTKE,
*Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on S. 2868, 94th Congress, a bill "To provide chiropractic treatment when requested for veterans eligible for outpatient medical care."

The subject bill would amend chapter 17 of title 38, United States Code, by adding a new section 629 at the end of subchapter III of such chapter. The new section 629 would authorize the furnishing of chiropractic care for any veteran eligible for medical services who requests such care. The doctor of chiropractic furnishing such care would be required to hold a degree of doctor of chiropractic from a school or college approved by the Administrator, and be licensed in a State or territory, or in the District of Columbia, and have practiced for at least 2 years.

The bill proposes, in effect, that the veteran patient would determine the type of treatment he needs since, if he requested chiropractic care, we apparently would have no choice but to furnish such care without regard to the condition requiring treatment or the type of care medically indicated. This, of course, would not be professionally acceptable, nor would it serve the best interests of the veteran.

When sound medical findings and judgment determine that active manipulation and adjustment is indicated, such treatment is accomplished by physical therapists in our Department of Medicine and Surgery under the supervision of practitioners of the regular schools of medicine. Moreover, our general counsel has held that the need for the utilization of the services of chiropractors to provide treatment to veterans should be determined on a case-by-case basis by a duly qualified medical physician.

We seek to make available to veterans medical care and treatment of the highest caliber whether the service is furnished within the agency or under contracts with private organizations and individuals. To this end, we have been highly successful in enlisting the assistance and cooperation of all of the regular schools of medicine.

It is not possible, because of the indeterminate factors involved, to submit a worthwhile estimate of the cost of the bill, if enacted.

For the foregoing reasons, we oppose the enactment of S. 2868.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely,

RICHARD L. ROUDEBUSH,
Administrator.

[No. 100]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., March 15, 1976.

HON. VANCE HARTKE,
*Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of January 29, 1976, for the views of this Office on S. 2869, a bill "To provide chiropractic treatment when requested for veterans eligible for outpatient medical care."

In its report to your Committee on S. 2868, the Veterans' Administration explains its reasons for recommending against favorable action on the bill. We concur in the views expressed in the report of the Veterans' Administration and, accordingly, recommend against the enactment of S. 2868.

Sincerely,

(Signed) James M. Frey
JAMES M. FREY,

Assistant Director for Legislative Reference.

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., February 6, 1975.

HON. NELSON A. ROCKEFELLER,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: There is transmitted herewith a draft of a bill "to amend title 38, United States Code, to require that certain veterans receiving hospital care from the Veterans' Administration for non-service-connected disabilities be charged for such care to the extent that they have health insurance or similar contracts with respect to such care; to prohibit the future exclusion of such coverage from insurance policies or contracts; and for other purposes," with the request that it be introduced in order that it may be considered for enactment.

This bill was originally submitted to the 91st Congress on February 26, 1970, as part of the Federal Economy Act of 1970. Following resubmission to the 92d Congress, by letters of January 26, 1971, it was introduced as S. 2807, 92d Congress. The bill was again resubmitted to the 93d Congress, by letters of March 14, 1973, and introduced as H.R. 5936, 93d Congress.

Under existing law, a veteran of any war or of service after January 31, 1955, who is under age 65, is eligible for necessary hospital care for a non-service-connected disability if he is unable to defray the expenses of private hospital care. (Veterans who are age 65' or older are entitled to such care without regard to their ability to bear the cost of private care.) We cannot administratively deny hospital admission to veterans who file the required statement of inability to pay, even though they have private hospitalization coverage.

Veterans' Administration regulations, for many years, have provided for the taking of an assignment of the veteran's rights to the extent of the cost of non-service-connected hospital and medical care for which third parties are or may become liable. Such liability may be based on an insurance contract or plan which provides for payment or reimbursement of the cost of medical or hospital care. It could arise under workmen's compensation or employer's liability statutes. Or, it might result from a tortious act or omission causing the injury for which care and treatment was furnished. Our program for the recovery of hospital costs from tortiously liable third parties was strengthened by the enactment of the Federal Medical Care Recovery Act (Pub. L. 87-693) in 1962.

Commercial insurance companies generally recognized their liability for Veterans' Administration hospital costs under hospital reimbursement insurance contracts prior to the adverse decision of the Court of Appeals for the 8th Circuit in 1956 in the case of *United States v.*

Saint Paul Mercury Indemnity Insurance Company, 238 F. 2d 594. In denying the Government's claim for recovery of Veterans' Administration hospital costs for care of a veteran suffering from a non-service-connected condition, the court held that the health insurance carrier was not liable because the veteran-insured did not actually incur any expense to himself. The effect of the decision, which remains unchallenged, and the further fact that almost all hospitalization insurance contracts now contain clauses relieving the carrier from liability where the service is provided by the Veterans' Administration, have virtually eliminated health insurance policies as a source of recovery of Veterans' Administration non-service-connected hospitalization costs.

The Veterans' Administration adheres to its long-standing position that the United States should not bear the cost of hospitalization of veterans for non-service-connected disabilities, where to do so would benefit third parties, including insurance companies, who are legally liable for the expenses arising from the disability or injury necessitating such care. Consistent with this objective, the draft bill, if enacted, would require that non-service-connected veterans be charged for care in a Veterans' Administration hospital to the extent that they are entitled to care, or reimbursement for the cost of care, under a health insurance policy or contract. It would also prohibit, prospectively, the exclusion of Veterans' Administration non-service-connected hospitalization from coverage under such policies or contracts if such care would be covered when furnished by other public or private facilities. The bill would be effective the first day of the first month which begins 90 days after the date of enactment. This deferred date would give affected insurance companies time to redraft future contracts in conformity with the new law.

We estimate that the enactment of this bill would save the Government some \$122 million during the first year and each year thereafter.

Accordingly, the Veterans' Administration recommends the favorable consideration by the Congress of the enclosed draft bill.

Advice has been received from the Office of Management and Budget that there is no objection to the presentation of this proposed legislation, and that its enactment would be in accord with the program of the President.

Sincerely,

RICHARD L. ROUDEBUSH,
Administrator.

Enclosure.

A BILL To amend title 38 of the United States Code to require that certain veterans receiving hospital care from the Veterans' Administration for non-service-connected disabilities be charged for such care to the extent that they have health insurance or similar contracts with respect to such care; to prohibit the future exclusion of such coverage from insurance policies or contracts; and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 610 of title 38, United States Code, is amended by adding at the end thereof a new subsection (d) :

“(d) A veteran furnished hospital care pursuant to subsections (a) (1)(B) and (a) (4) of this section who is entitled to care or reimbursement for the expenses of such care under an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for health services shall be charged for such care to the extent of such entitlement, and no such contract or arrangement entered into, renewed, changed, or amended, after the effective date of this subsection shall exclude from coverage the charges for hospital care furnished pursuant to subsections (a) (1)(B) and (a) (4) of this section and section 611(b) of this title if such care would be covered when furnished by other public or private facilities. Where such contract or arrangement provides for payment of less than the total charge for care and the insured veteran is entitled to care without charge under this chapter, the veteran shall be deemed to have paid that part of the charge not payable by the contract or arrangement.”

SEC. 2. This act shall take effect on the first day of the first month which begins 90 days after the date of enactment.

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, D.C., January 26, 1976.

HON. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on H.R. 2735, 94th Congress, an act "To amend title 38 of the United States Code in order to provide for an annual investigation by the Administrator into the cost of travel by veterans to Veterans' Administration facilities, and to set rates therefor, and for other purposes."

The subject bill would amend section 111 of title 38, to require the Administrator to conduct annual investigations of the cost of travel (including lodging and subsistence), and the operation of privately owned vehicles to beneficiaries while traveling to or from a Veterans' Administration facility. Factors to be considered in such investigation would include depreciation of original vehicle costs; gasoline and oil costs; maintenance, accessories, parts, and tires; insurance; State and Federal taxes; and the expenses of employee travel. Reports of such investigations would be submitted annually to the Committees on Veterans' Affairs of the Senate and the House of Representatives.

Under current law (section 111(a) of title 38, United States Code), a VA beneficiary who travels in connection with Veterans' Administration vocational rehabilitation, counseling, or for the purpose of examination, treatment, or care, may pay his own necessary expenses of travel by personally owned conveyance and be reimbursed on a mileage basis; he may pay his own expenses of travel and be repaid for actual and necessary expenses; or he may obtain a Government Transportation Request from the VA for presentation to the ticket office in exchange for his bus or train ticket. Should the veteran choose the last option, he may also obtain from the VA reimbursement for any necessary expenses for meals and lodging. The authority of the President, pursuant to section 111(a) of title 38, to set rates for travel of certain VA Affairs by Executive Order 11609, dated July 22, 1971. Currently, the allowance may be fixed by the Administrator in such amount per mile as he determines.

We periodically make studies to determine the adequacy of beneficiary travel allowances. Those studies to date have considered the "out of pocket" expenses involved in the operation of a motor vehicle, and have not taken into consideration such factors as depreciation of the original vehicle cost, insurance, taxes, or the relative rates paid Federal employees traveling on official business.

It should be pointed out that a Government employee traveling by private automobile may be reimbursed at a rate higher than the currently authorized rate for VA beneficiaries only when such travel is determined to be for the convenience of the Government. When the employee uses his automobile for his own convenience, his reimbursement is limited to the cost of common carrier transportation, or to the cost of Government owned conveyance.

We believe the private automobile usage situation of VA beneficiaries is generally distinguishable from that of a government employee who uses his automobile for the convenience of the Government, since use of a privately owned vehicle is usually for his own personal convenience. On the other hand, we realize there may be situations where commercial transportation facilities are not readily available or where the veteran beneficiary may have a physically disabling condition which would make it unwise, if not extremely difficult, to use such public transportation facilities. Under these circumstances, we believe the use of the veteran beneficiary's private automobile might be akin to those situations where the use of a private automobile by a Federal employee is deemed to be for the convenience of the Government. Accordingly, I am directing a complete reevaluation of our policy with respect to beneficiary travel, to see if a reimbursement procedure should be established which will distinguish between those situations where travel is purely for the convenience of the traveler, and those situations where private vehicle travel can be considered a necessity, and, therefore, could be deemed to be for the convenience of the Government. Where the latter type of situation exists, I am considering broadening our rate setting procedures to include some of the additional factors which are considered in establishing rates for Federal employee travel deemed to be for the convenience of the Government. Upon completion of this study, I will be establishing a revision of our current mileage and per diem rates.

I believe the reevaluation of our rate setting procedures, which is now underway, demonstrates the desirability of having the type of general authority now contained in 38 U.S.C. 111, which can be used to make rapid administrative change when the need is presented. I also believe it demonstrates that I now have sufficient authority to accomplish the basic purpose sought to be achieved by the subject bill. Furthermore, I do not believe that a replacement of the current flexible authority with a set of specific guidelines, such as would be provided by H.R. 2735, would be desirable. Accordingly, we are opposed to the enactment of such bill.

We are unable to estimate the cost of implementing H.R. 2735, since the cost would depend on the results of our investigation into the costs of beneficiary travel using the factors required by the bill.

We were advised by the Office of Management and Budget that there was no objection from the standpoint of the Administration's program to the presentation of an identical report to the Chairman, Committee on Veterans' Affairs, House of Representatives, on H.R. 2735.

Sincerely,

RICHARD L. ROUDEBUSH,
Administrator.

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., January 30, 1976.

HON. VANCE HARTKE,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This will respond to your request for a report by the Veterans' Administration on H.R. 1547, 94th Congress, an act "To amend title 38 of the United States Code in order to extend medical benefits to the survivors of any veteran who at the time of death was suffering from a total and permanent service-connected disability."

The subject bill would provide medical care for the widow or child of a veteran who, at the time of death, had a total disability, permanent in nature, resulting from a service-connected disability. Section 613 (a), as currently worded, provides medical care for the wife or child of any veteran who has a total disability, permanent in nature, resulting from a service-connected disability. It also provides medical care for the widow or child of any veteran who died as a result of a service-connected disability. This means that the wife or child who may be currently eligible for medical care by reason of the veteran having a total disability, permanent in nature, resulting from a service-connected disability, loses that entitlement in the event the veteran dies of a non-service-connected cause.

We favor the proposed bill because it follows a long-standing and justifiable practice of recognizing that a veteran who has a service-connected total disability is in a special category and deserving of assistance for the sacrifices he and his family have made. The bill would provide for the widow or child of a veteran who died as a result of a non-service-connected cause, while a total and permanent service-connected disability was in existence, to continue to receive an adequate level of medical care without the need and inconvenience of arranging for another source of care and possibly with some lessening of the scope and/or effectiveness of the care received. This amendment would bring the treatment of such widow and child under the CHAMPVA program in line with that applicable to the survivors of a former serviceman under the CHAMPUS program, upon which it was based.

Enactment of the subject bill would result in an estimated annual cost to the Veterans' Administration of \$56,984.

We were advised by the Office of Management and Budget that there was no objection from the standpoint of the Administration's program to the presentation of an identical report to the Chairman, Committee on Veterans' Affairs, House of Representatives, on H.R. 1547.

Sincerely,

RICHARD L. ROUDEBUSH,
Administrator.

CHANGES IN EXISTING LAW MADE BY S. 2908, AS REPORTED

In accordance with subsection 4 of Rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman) :

TITLE 38—UNITED STATES CODE

* * * * *

PART I—GENERAL PROVISIONS

* * * * *

CHAPTER 1—GENERAL

* * * * *

§ 111. Travel expenses

(a) Under regulations prescribed by the President *pursuant to the provisions of this section*, the Administrator may pay the actual necessary expense of travel (including lodging and subsistence), or in lieu thereof an allowance based upon mileage traveled, of any person to or from a Veterans' Administration facility or other place in connection with vocational rehabilitation, counseling required by the Administrator pursuant to chapter 34 or 35 of this title, or for the purpose of examination, treatment, or care. In addition to the mileage allowance authorized by this section, there may be allowed reimbursement for the actual cost of ferry fares, and bridge, road, and tunnel tolls.

(b) Payment of the following expenses or allowances in connection with vocational rehabilitation, counseling, or upon termination of examination, treatment, or care, may be made before the completion of travel:

(1) the mileage allowance authorized by subsection (a) hereof;

(2) actual local travel expenses;

(3) the expense of hiring an automobile or ambulance, or the fee authorized for the services of a nonemployee attendant.

(c) When any person entitled to mileage under this section requires an attendant (other than an employee of the Veterans' Administration) in order to perform such travel, the attendant may be allowed expenses of travel upon the same basis as such person.

(d) The Administrator may provide for the purchase of printed reduced-fare requests for use by veterans and their authorized attendants when traveling at their own expense to or from any Veterans' Administration facility.

(e) (1) *In carrying out the purposes of this section, the Administrator, in consultation with the Administrator of General Services, the Secretary of Transportation, the Comptroller General of the United States, and representatives of organizations of veterans, shall conduct periodic investigations of the actual cost of travel (including*

lodging and subsistence) to beneficiaries while traveling to or from a Veterans' Administration facility or other place pursuant to the provisions of this section, and the estimated cost of alternative modes of travel, including public transportation and the operation of privately owned vehicles. The Administrator shall conduct such investigations immediately following any alteration in the rates described in paragraph (3) (C) of this subsection, and, in any event, immediately following the enactment of this subsection, and, in any event, immediately following the enactment of this subsection and not less than annually thereafter, and, based thereon, shall determine rates of allowances or reimbursement to be paid under this section.

(2) In no event shall payment be provided under this section—

(A) unless the person claiming reimbursement has been determined, based on an annual declaration and certification by such person, to be unable to defray the expenses of such travel (except with respect to a veteran receiving benefits for or in connection with a service-connected disability under this title);

(B) to reimburse for the cost of travel by privately owned vehicles in any amount in excess of the cost of such travel by public transportation unless (i) public transportation is not reasonably accessible or would be medically inadvisable, or (ii) the cost of such travel is not greater than the cost of public transportations; and

(C) in excess of the actual expense incurred by such person as certified in writing by such person.

(3) In conducting investigations and determining rates under this section, the Administrator shall review and analyze, among other factors, the following factors:

(A) (i) Depreciation of original vehicle costs;

(ii) gasoline and oil costs;

(iii) maintenance, accessories, parts, and tires costs;

(iv) insurance costs; and

(v) State and Federal taxes.

(B) The availability of and time required for public transportation.

(C) The per diem rates, mileage allowances, and expenses of travel authorized under sections 5702 and 5704 of title 5 for employees of the United States.

(4) Before determining rates under this section, and not later than sixty days after the date of the enactment of this subsection, and thereafter not later than sixty days after any alteration in the rates described in paragraph (3) (C) of this subsection, the Administrator shall publish in the Federal Register and submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing the rates the Administrator proposes to establish or continue with a full justification therefor in terms of each of the limitations and factors set forth in this section. The justification provided under this paragraph shall specify the extent to which and the full reasons why the proposed rates would differ from the rates in effect under sections 5702 and 5704 of title 5 for employees of the United States traveling on official business.

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CHAPTER 3—VETERANS' ADMINISTRATION; OFFICERS AND EMPLOYEES

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SUBCHAPTER II—ADMINISTRATOR OF VETERANS' AFFAIRS

Sec.

- 210. Appointment and general authority of Administrator; Deputy Administrator.
- 211. Decisions by Administrator; opinions of Attorney General.
- 212. Delegation of authority and assignment of duties.
- 213. Contracts and personal services.
- 214. Report to the Congress.
- 215. Publication of laws relating to veterans.
- [216. Research by Administrator; indemnification of contractors.]**
- 217. Studies of rehabilitation of disabled persons.
- 218. Standards of conduct and arrests for crimes at hospitals, domiciliaries, cemeteries, and other Veterans' Administration reservations.
- 219. Evaluation and data collection.
- 220. Coordination of other Federal programs affecting veterans and their dependents.

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Subchapter II—Administrator of Veterans' Affairs

* * * * *

[§ 216. Research by Administrator; indemnification of contractors

[(a) (1) The Administrator shall conduct research in the field of prosthesis, prosthetic appliances, orthopedic appliances, and sensory devices.

[(2) In order that the unique investigative materials and research data in the possession of the Government may result in improved prosthesis, prosthetic appliances, orthopedic appliances, and sensory make available to any person the results of his research.

[(3) There are authorized to be appropriated annually, to remain available until expended, such funds as may be necessary to carry out this section.

[(b) (1) With the approval of the Administrator, any contract for research authorized by this section or for medical research or development authorized by section 4101 of this title, the performance of which involves a risk of an unusually hazardous nature, may provide that the United States will indemnify the contractor against either or both of the following, but only to the extent that they arise out of the direct performance of the contract and to the extent not covered by the financial protection required under subsection (b) (5)—

[(A) liability (including reasonable expenses of litigation or settlement) to third persons, except liability under State or Federal Workmen's Compensation Acts to employees of the contractor employed at the site of and in connection with the contract for which indemnification is granted, for death, bodily injury, or loss of or damage to property, from a risk that the contract defines as unusually hazardous.

[(B) loss of or damage to property of the contractor from a risk that the contract defines as unusually hazardous.

[(2) A contract that provides for indemnification in accordance with subsection (b) (1) must also provide for—

[(A) notice to the United States of any claim or suit against the contractor for death, bodily injury, or loss of or damage to property; and

[(B) control of or assistance in the defense by the United States, at its election, of any such suit or claim for which indemnification is provided hereunder.

[(3) No payment may be made under subsection (b) (1) unless the Administrator, or his designee, certifies that the amount is just and reasonable.

[(4) Upon approval by the Administrator, payments under subsection (b) (1) may be made from—

[(A) funds obligated for the performance of the contract concerned;

[(B) funds available for research or development, or both, and not otherwise obligated; or

[(C) funds appropriated for those payments.

[(5) Each contractor which is a party to an indemnification agreement under subsection (b) (1) shall have and maintain financial protection of such type and in such amounts as the Administrator shall require to cover liability to third persons and loss of or damage to the contractor's property. The amount of financial protection required shall be the maximum amount of insurance available from private sources, except that the Administrator may establish a lesser amount, taking into consideration the cost and terms of private insurance. Such financial protection may include private insurance, private contractual indemnities, self-insurance, other proof of financial responsibility, or a combination of such measures.

[(6) In administering the provisions of this section, the Administrator may use the facilities and services of private insurance organizations, and he may contract to pay a reasonable compensation therefor. Any contract made under the provisions of this subsection may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5), upon a showing by the Administrator that advertising is not reasonably practicable, and advance payments may be made.

[(7) The authority to indemnify contractors under this section does not create any rights in third persons which would not otherwise exist by law.

[(8) As used in his section, the term "contractor" includes subcontractors of any tier under a contract in which an indemnification provision pursuant to subsection (b) (1) is contained.

[(c) For each fiscal year in the period beginning July 1, 1966, and ending June 30, 1972, the Administrator shall set aside not less than \$100,000 of funds appropriated for medical research, authorized by section 4101 of this title, for the conduct of research into spinal cord injuries and diseases, and other disabilities that lead to paralysis of the lower extremities.]

PART II—GENERAL BENEFITS

CHAPTER	Sec.
11. Compensation for Service-Connected Disability or Death-----	301
13. Dependency and Indemnity Compensation for Service-Connected Deaths -----	401
15. Pension for Non-Service-Connected Disability or Death or for Service-----	501
17. Hospital, <i>Nursing Home</i> , Domiciliary, and Medical Care-----	601
19. Insurance-----	
21. Specially Adapted Housing for Disabled Veterans-----	801
23. Burial Benefits-----	901
24. National Cemeteries and Memorials-----	1000

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CHAPTER 17—HOSPITAL, *NURSING HOME*, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I—GENERAL

Sec.

- 601. Definitions.
- 602. Presumption relating to psychosis.
- 603. *Presumption relating to internment as prisoner of war.*

SUBCHAPTER II—HOSPITAL, *NURSING HOME*, OR DOMICILIARY CARE AND MEDICAL TREATMENT

- 610. Eligibility for hospital, *nursing home*, and domiciliary care.
- 611. **[Hospitalization]** *Care* during examinations and in emergencies.
- 612. Eligibility for medical treatment.
- 612A. *Eligibility for readjustment professional counseling.*
- 613. Medical care for survivors and dependents of certain veterans.
- 614. Fitting and training in use of prosthetic appliances; seeing-eye dogs.
- 615. Tobacco for hospitalized veterans.
- 616. Hospital care by other agencies of the United States.
- 617. Invalid lifts and other devices.
- 618. Therapeutic and rehabilitative activities.
- 619. Repair or replacement of certain prosthetic and other appliances.
- 620. Transfers for nursing home care.
- 620A. *Treatment and rehabilitation for alcoholism*

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND *NURSING* *HOME CARE* AND MEDICAL TREATMENT OF VETERANS

- 621. Power to make rules and regulations.
- 622. Statement under oath.
- 623. Furnishing of clothing.
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Subchapter I—General

§ 601. Definitions

For the purposes of this chapter—

(1) The term “disability” means a disease (*including alcoholism and drug dependence*), injury, or other physical or mental defect.

(2) The term “veteran of any war” includes any veteran of the Indian Wars, or any veteran awarded the Medal of Honor.

(3) The term “period of war” includes each of the Indian Wars.

(4) The term “Veterans’ Administration facilities” means—

(A) facilities over which the Administrator has direct [and exclusive] jurisdiction;

(B) Government facilities for which the Administrator contracts; and

(C) private facilities for which the Administrator contracts *when facilities described in clause (A) or (B) of this paragraph are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the care or services required in order to provide (i) hospital care or medical services [for persons suffering from service-connected disabilities or from disabilities for which such persons were] to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service; (ii) medical services for the treatment of any disability of a veteran described in clause (1) (B) or (2) of section 612(f) of this title; (iii) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care in a facility described in clause (A) or (B) of this paragraph; [(ii)] (iv) hospital care for women veterans; or [(iii)] (v) hospital care for veterans in a State, territory, Commonwealth, or possession of the United States not contiguous to the forty-eight contiguous States, except that the annually determined average hospital patient load per thousand veteran population hospitalized at Veterans’ Administration expense in Government and private facilities in each such noncontiguous State may not exceed the average patient load per thousand veteran population hospitalized by the Veterans’ Administration within the forty-eight contiguous States; but authority under this [clause (iii)] sub-clause (v) shall expire on December 31, 1978.*

(5) The term “hospital care” includes—

(A) (i) medical services *and rehabilitative services* rendered in the course of the hospitalization of any veteran, and (ii) transportation and incidental expenses [for any veteran who is in need of treatment for a service-connected disability or is unable to defray the expense of transportation] *pursuant to the provisions of section 111 of this title;*

(B) such mental health services, consultation, professional counseling, and training [(including (i) necessary expenses for

transportation if unable to defray such expenses; or (ii) necessary expenses of transportation and subsistence in the case of a veteran who is receiving care for a service-connected disability, or in the case of a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title, under the terms and conditions set forth in section 111 of this title) of the members of the immediate family (including legal guardians) of a veteran or such a dependent or survivor of a veteran, or, in the case of a veteran or such dependent or survivor of a veteran who has no immediate family members (or legal guardian), the person in whose household such veteran, or such a dependent or survivor certifies his intention to live, as may be necessary or appropriate to the effective treatment and rehabilitation of a veteran or such a dependent or a survivor of a veteran; *for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of a veteran or dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title; and*

(C) (i) medical services rendered in the course of the hospitalization of a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title, and (ii) transportation and incidental expenses for such dependent or survivor of a veteran who is in need of treatment for any injury, disease, or disability and is unable to defray the expense of transportation.

[(6) The term "medical services" includes, in addition to medical examination and treatment, such home health services as the Administrator determines to be necessary or appropriate or the effective and economical treatment of a disability of a veteran or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title, optometrists' services, dental and surgical services, and (except under the conditions described in section 612(f)(1)) dental appliances, wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies as the Administrator determines to be reasonable and necessary.]

(6) *The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—*

(A) *(i) surgical services, dental services and appliances as authorized in section 612 (b), (c), (d), and (e) of this title, optometric and podiatric services, and (except under the conditions described in section 612(f)(1)(A) of this title) wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services (including the maintenance of patient drug profiles, patient drug monitoring, and drug utilization education) as the Administrator determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of sections 111 of this title; and*

(B) such—

(i) consultation, professional counseling, and training, and

(ii) mental health services in connection with the treatment of (I) the service-connected disability of a veteran pursuant to section 612(a), or the readjustment problem of a veteran pursuant to section 612A, of this title, and (II) in the discretion of the Administrator, other disabilities related to the mental health of a veteran pursuant to section 612(f) (1) (B) of this title where such services were initiated during the veteran's hospitalization,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, necessary expenses of travel and subsistence of such family member or individual in the case of a veteran who is receiving care for a service-connected disability or in the case of a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title). For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title shall be eligible for the same medical services as a veteran.

(7) The term "domiciliary care" includes necessary medical services and [transportation] travel and incidental expenses [for veterans who are unable to defray the expense of transportation] pursuant to the provisions of section 111 of this title.

(8) The term "rehabilitative services" means such professional, counseling, and guidance services and treatment programs (other than those types of vocational rehabilitation services provided under chapter 31 of this title) as are necessary to restore the physical, mental, and psychological functioning of an ill or disabled person.

* * * * *

§ 603. Presumption relating to internment as prisoner of war

For the purposes of this chapter, the disability of any veteran who was for more than six months a prisoner of war, as provided in section 312(c) of this title, shall be deemed to have been incurred in the active military, naval, or air service if such disability, on the basis of sound medical judgment, could be attributable to or aggravated by the internment of such veteran as a prisoner of war unless the Administrator finds, on the basis of clear and convincing evidence, that the disability was not attributable to or aggravated by such internment.

Subchapter II—Hospital, Nursing Home, or Domiciliary Care and Medical Treatment

§ 610. Eligibility for hospital, nursing home, and domiciliary care

(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which [he] the Administrator determines is needed to—

(1) (A) any veteran for a service-connected disability; or (B) any veteran for a non-service-connected disability if [he] such

veteran is unable to defray the expenses of necessary hospital or nursing home care;

(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

(3) a person who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation; and

(4) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older.

(b) The Administrator, within the limits of Veterans' Administration facilities, may furnish domiciliary care to—

(1) a veteran who was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when [he] *such person* is suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and is incapacitated from earning a living and has no adequate means of support; and

(2) a veteran [of any war or of service after January 31, 1955,] who is in need of domiciliary care [.] if [he] *such veteran* is unable to defray the expenses of necessary domiciliary care.

(c) While any veteran is receiving hospital care or nursing home care in any Veterans' Administration facility, the Administrator may, within the limits of Veterans' Administration facilities, furnish medical services to correct or treat any non-service-connected disability of such veteran, in addition to treatment incident to the disability for which [he] *such veteran* is hospitalized, if the veteran is willing, and the Administrator finds such services to be reasonably necessary to protect the health of such veteran.

(d) In no case may nursing home care be furnished in a hospital not under the direct [and exclusive] jurisdiction of the Administrator except as provided in section 620 of this title.

§ 611. [Hospitalization] Care during examinations and in emergencies

(a) The Administrator may furnish hospital care incident to physical examinations where such examinations are necessary in carrying out the provisions of other laws administered by [him] *the Administrator*.

(b) The Administrator may furnish hospital care or medical services as a humanitarian service in emergency cases, but [he] *the Administrator* shall charge for such care at rates prescribed by [him] *the Administrator*.

§ 612. Eligibility for medical treatment

(a) Except as provided in subsection (b), the Administrator, within the limits of Veterans' Administration facilities, may furnish such medical services as [he] *the Administrator* finds to be reasonably necessary to any veteran for a service-connected disability. *The Administrator may also furnish to any such veteran such home health services as the Administrator finds to be necessary or appropriate for the effective and economical treatment of such disability (including only such improvements and structured alterations (or reimbursement for an appropriate portion of the cost thereof) as are necessary*

to assure the continuation of treatment for such disability or to provide access to the home or to essential lavatory and sanitary facilities, and the cost of which does not exceed the cost of the average period of hospitalization under section 610 of this title, as determined annually by the Administrator). In the case of any veteran discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, such services may be so furnished for that disability, whether or not service-connected for the purposes of this chapter.

(b) Outpatient dental services and treatment, and related dental appliances, shall be furnished under this section only for a dental condition or disability—

(1) which is service-connected and compensable in degree;

(2) which is service-connected, but not compensable in degree, but only (A) if it is shown to have been in existence at time of discharge or release from active military, naval, or air service and (B) if application for treatment is made within one year after such discharge or release, except that if a disqualifying discharge or release has been corrected by competent authority, application may be made within one year after the date of correction or the date of enactment of this exception, whichever is later;

(3) which is a service-connected dental condition or disability due to combat wounds or other service trauma, or of a former prisoner of war;

(4) which is associated with and is aggravating a disability (A) resulting from some other disease or injury which was incurred in or aggravated by active military, naval, or air service, or (B) for which such veteran is receiving treatment (not including routine dental care); [or]

(5) which is a non-service-connected condition or disability of a veteran for which treatment was begun while such veteran was receiving hospital care under this chapter and such services and treatment are reasonably necessary to complete such treatment; or

[(5)](6) from which a veteran of the Spanish-American War or Indian-Wars is suffering.

(c) Dental services and related appliances for a dental condition of disability described in clause (2) of subsection (b) of this section shall be furnished on a one-time completion basis, unless the services rendered on a one-time completion basis are found unacceptable within the limitations of good professional standards, in which event such additional services may be afforded as are required to complete professionally acceptable treatment.

(d) Dental appliances, wheelchairs, artificial limbs, trusses, special clothing, and similar appliances to be furnished by the Administrator under this section may be procured by [him] the Administrator either by purchase or by manufacture, whichever [he] the Administrator determines may be advantageous and reasonably necessary.

(e) Any disability of a veteran of the Spanish-American War or Indian [wars] Wars, upon application for the benefits of this section or outpatient medical services under section 624 of this title, shall be considered for the purposes thereof to be a service-connected disability incurred or aggravated in a period of war.

(f) The Administrator [may also furnish], *within the limits of Veterans' Administration facilities, may furnish* medical services for any disability on an outpatient or ambulatory basis—

(1) to any veteran eligible for hospital care under section 610 of this title (A) where such services are reasonably necessary in preparation for, or (*to the extent that facilities are available*) to obviate the need of, hospital admission, or (B) where such a veteran has been [granted] *furnished* hospital care and such medical services are reasonably necessary to complete treatment incident to such hospital care (*for a period not in excess of twelve months after discharge from in-hospital treatment, except where the Administrator finds (i) that a longer period is required by virtue of the disability being treated, and (ii) with respect to private facilities for which the Administrator contracts, that alternative Federal reimbursement is not reasonably available to defray substantially the costs of such treatment*); and

(2) to any veteran who has a service-connected disability rated at [80] 50 per centum or more.

The Administrator may also furnish to any such veteran such home health services as the Administrator determines to be necessary or appropriate for the effective and economical treatment of a disability of a veteran (including only such improvements and structural alterations (or reimbursement for an appropriate portion of the cost thereof) are of a minor nature and are necessary to assure the continuation of treatment or provide access to the home or to essential lavatory sanitary facilities).

(g) Where any veteran is in receipt of increased pension or additional compensation or allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance, the Administrator, *within the limits of Veterans' Administration facilities*, may furnish the veteran such medical services as [he] the Administrator finds to be reasonably necessary.

(h) The Administrator shall furnish to each veteran who is receiving additional compensation or allowance under chapter 11, or increased pension as a veteran of the Mexican border period, World War I, World War II, the Korean conflict, or the Vietnam era, by reason of being permanently housebound or in need of regular aid and attendance, such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of any illness or injury suffered by such veteran. The Administrator shall continue to furnish such drugs and medicines so ordered to any such veteran in need of regular aid and attendance whose pension payments have been discontinued solely because [his] *such veteran's* annual income is greater than the applicable maximum annual income limitation, but only so long as [his] *such veteran's* annual income does not exceed such maximum annual income limitation by more than \$500.

(i) *Not later than ninety days after the date of enactment of this subsection, the Administrator shall prescribe regulations to ensure that special priority in furnishing medical services under this section and any other outpatient care with funds appropriated for the medical care of veterans shall be accorded in the following order, except in*

the case of medical emergencies which pose a serious threat to life or health:

- (1) To any veteran for a service-connected disability.*
- (2) To any veteran described in subsection (f)(2) of this section.*
- (3) To any veteran with a disability rated as service-connected or eligible, by reason of section 612A of this title, for outpatient mental health services under section 612(f)(1)(B) of this title.*
- (4) To any veteran being furnished medical services under subsection (g) of this section.*

§ 612A. Eligibility for readjustment professional counseling

(a) The Administrator may furnish initial readjustment professional counseling (including a general mental and psychological assessment in connection therewith), and travel and incidental expenses pursuant to the provisions of section 111 of this title for any veteran who served after August 4, 1964, and who requests assistance with readjustment problems within a period not to exceed four years after the date of such veteran's discharge or release from service, or two years after the date of the enactment of this section, whichever is later.

(b) If, on the basis of initial counseling furnished under subsection (a) of this section, it is determined that the provision of mental health services is necessary to facilitate the successful readjustment of the veteran, such veteran shall be furnished such services on an outpatient basis as a part of medical services provided under the conditions specified in clause (1)(B) of section 612(f) of this title. For the purposes of furnishing such services, the counseling furnished under subsection (a) of this section shall be deemed to have been furnished as a part of hospital care. Any hospital care and other medical services deemed necessary as a result of such initial counseling shall be furnished in accordance with the eligibility criteria otherwise set forth in this chapter (including section 611(b) thereof), and where a particular veteran is not eligible for necessary care or services, the Administrator shall provide referral services to assure, to the maximum extent practicable, that such care or services are provided from sources outside the Veterans' Administration.

(c) The Chief Medical Director shall provide for such training of professional, paraprofessional, and lay personnel as is necessary to carry out this section effectively, and shall make maximum utilization of the services of paraprofessionals, voluntary (without compensation) workers, and veteran students (under section 1685 of this title) in initial intake and screening activities.

(d) The Administrator, in cooperation with the Secretary of Defense, shall take appropriate action, as provided in 241 of this title, to ensure that all veterans eligible for such assistance and are encouraged to take full advantage thereof.

§ 613. Medical care for survivors and dependents of certain veterans

(a) The Administrator is authorized to provide medical care, in accordance with the provisions of subsection (b) of this section, for—

(1) the wife or child of a veteran who has a total disability, permanent in nature, resulting from a service-connected disability, and

(2) the widow or child of a veteran who (A) died as a result of a service-connected disability, or (B) at the time of death had a total disability permanent in nature, resulting from a service-connected disability,

who are not otherwise eligible for medical care under chapter 55 of title 10 (CHAMPUS).

(b) In order to accomplish the purposes of subsection (a) of this section, the Administrator shall provide for medical care in the same or similar manner and subject to the same or similar limitations as medical care is furnished to certain dependents and survivors of active duty and retired members of the Armed Forces under chapter 55 of title 10 (CHAMPUS), by—

(1) entering into an agreement with the Secretary of Defense under which the Secretary shall include coverage for such medical care under the contract, or contracts, [he] the Secretary enters into to carry out such chapter 55, and under which the Administrator shall fully reimburse the Secretary for all costs and expenditures made for the purposes of affording the medical care authorized pursuant to this section; or

(2) contracting in accordance with such regulations as [he] the Administrator shall prescribe for such insurance, medical service, or health plans as [he] the Administrator deems appropriate.

In cases in which Veterans' Administration medical facilities are particularly equipped to provide the most effective care and treatment, the Administrator is also authorized to carry out such purposes through the use of such facilities not being utilized for the care of eligible veterans.

§ 614. Fitting and training in use of prosthetic appliances; seeing-eye dogs

(a) Any veteran who is entitled to a prosthetic appliance shall be furnished such fitting and training, including institutional training, on the use of such appliance as may be necessary, whether in a Veterans' Administration facility or other training institution, or by outpatient treatment, including such service under contract, and including necessary travel expenses to and from [his] such veteran's home to such hospital or training institution.

(b) The Administrator may provide seeing-eye or guide dogs trained for the aid of the blind to veterans who are entitled to disability compensation, and [he] may pay all necessary travel expenses to and from their homes and incurred in becoming adjusted to such seeing-eye or guide dogs. The Administrator may also provide such veterans with mechanical or electronic equipment for aiding them in overcoming the handicap of blindness.

* * * * *

§ 616. Hospital care by other agencies of the United States

When so specified in an appropriation or other Act, the Administrator may make allotments and transfers to the Departments of Health, Education, and Welfare (Public Health Service), the Army, Navy, Air Force, or Interior, for disbursement by them under the

various headings of their appropriations, of such amounts as are necessary for the care and treatment of veterans entitled to hospitalization from the Veterans' Administration under this chapter. The amounts to be charged the Veterans' Administration for care and treatment of veterans in hospitals shall be calculated on the basis of a per diem rate approved by the [Bureau of the Budget] *Office of Management and Budget*.

* * * * *

§ 618. Therapeutic and rehabilitation activities

【The】 (a) *In providing rehabilitative services under this chapter, the Administrator, upon the recommendation of the Chief Medical Director, may utilize the services of patients and members in Veterans' Administration [hospitals and domiciliaries] health care facilities for therapeutic and rehabilitative purposes, at nominal remuneration, and such patients and members shall not under these circumstances be held or considered as employees of the United States for any purpose. The Administrator shall prescribe the conditions for the utilization of such services.*

(b) (1) *In furnishing rehabilitative services under this chapter, the Administrator, upon the recommendation of the Chief Medical Director, may enter into arrangements with private industry or other sources outside the Veterans' Administration to provide for therapeutic work for remuneration for patients and members in Veterans' Administration health care facilities.*

(2) *Notwithstanding any other provision of law, the Administrator may also furnish rehabilitative services under this subsection through arrangements with nonprofit entities to provide for such therapeutic work for such patients. The Administrator shall establish appropriate fiscal, accounting, management, recordkeeping, and reporting requirements with respect to the activities of any such nonprofit entity in connection with such arrangements.*

(c) (1) *There is hereby established in the Treasury of the United States a revolving fund known as the Veterans' Administration Special Therapeutic and Rehabilitation Activities Fund (hereinafter called the "fund") for the purpose of carrying out the provisions of subsection (b) of this section. Such amounts of the fund as the Administrator may determine to be necessary to establish and maintain operating accounts for the various rehabilitative services activities may be deposited in checking accounts in other depositories selected or established by the Administrator.*

(2) *All funds received by the Veterans' Administration under arrangements made under subsection (b) of this section, or by nonprofit entities described in paragraph (2) of such subsection, shall be deposited in or credited to the fund, and the Administrator shall pay out of the fund moneys to participants at rates not less than the wage rates specified in the Fair Labor Standards Act (29 U.S.C. 201 et seq.) and regulations prescribed thereunder for work of similar character.*

(3) *In connection with the establishment and operation of the fund, the Administrator shall transfer to the fund not to exceed \$2,000,000 from funds appropriated for the medical care of veterans. Any balance in the fund at the end of each fiscal year in excess of the estimated*

requirements for the ensuing two fiscal years shall be credited to the medical care appropriation.

(4) *The Chief Medical Director shall prepare, for inclusion in the annual report submitted to Congress under section 214 of this title, a description of the scope and achievements of activities carried out under this section (including pertinent data regarding productivity and wage rates) during the prior twelve months and an estimate of the needs of the program of therapeutic and rehabilitation activities to be carried out under this section for the ensuing fiscal year.*

(d) *In providing rehabilitative services under this chapter, the Administrator shall take appropriate action to make it possible for the patient to take maximum advantage of any benefits to which such patient is entitled under chapter 31, 34, or 35 of this title, and, if the patient is still receiving treatment of a prolonged nature under this chapter, the provision of rehabilitative services under this chapter shall be continued during, and coordinated with, the pursuit of education and training under such chapter 31, 34, or 35.*

(e) *The Administrator shall prescribe regulations to ensure that the priorities set forth in section 612(i) of this title shall be applied, insofar as practicable, to participation in therapeutic and rehabilitation activities carried out under this section.*

§ 619. Repair or replacement of certain prosthetic and other appliances

The Administrator may repair or replace any artificial limb, truss, brace, hearing aid, spectacles, or similar appliance (not including dental appliances) reasonably necessary to a veteran and belonging to [him] *such veteran* which was damaged or destroyed by a fall or other accident caused by a service-connected disability for which such veteran is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation.

§ 620. Transfers for nursing home care

(a) Subject to subsection (b) *and except as provided in subsection (e) of this section, the Administrator may transfer—*

(1) any veteran who has been furnished care by the Administrator in a hospital under the direct [and exclusive] jurisdiction of the Administrator, and

(2) any person (A) who has been furnished care in any hospital of any of the Armed Forces, (B) who the appropriate Secretary concerned has determined has received maximum hospital benefits but requires a protracted period of nursing home care, and (C) who upon discharge therefrom will become a veteran.

to any public or private institution not under the jurisdiction of the Administrator which furnishes nursing home care, for care at the expense of the United States, only if the Administrator determines that—

(i) such veteran has received maximum benefits from such care in such hospital, but will require a protracted period of nursing home care which can be furnished in such institution, and

(ii) the cost of such nursing home care in such institution will not exceed [40] 45 per centum of the cost of care furnished by the Veterans' Administration in a general hospital under the direct

and exclusive jurisdiction of the Administrator, as such cost may be determined [from time to time] *annually* by the Administrator, or not to exceed 50 per centum of such cost where determined necessary by the Administrator, upon recommendation of the Chief Medical Director, to provide adequate care.

Nursing home care may not be furnished pursuant to this section at the expense of the United States for more than six months in the aggregate in connection with any one transfer, except (I) in the case of the veteran whose hospitalization was primarily for a service-connected disability, or (II) where in the judgment of the Administrator a longer period is warranted in the case of any other veteran. Any veteran who is furnished care by the Administrator in a hospital in Alaska or Hawaii may be furnished nursing home care under the provisions of this section even if such hospital is not under the direct [and exclusive] jurisdiction of the Administrator.

(b) No veteran may be transferred or admitted to any institution for nursing home care under this section, unless such institution is determined by the Administrator to meet such standards as [he] *the Administrator* may prescribe. The standards prescribed and any report of inspection of institutions furnishing care to veterans under this section made by or for the Administrator shall, to the extent possible, be made available to all Federal, State, and local agencies charged with the responsibility of licensing or otherwise regulating or inspecting such institutions.

(c) In applying the provisions of section 2(b)(1) of the Service Contract Act of 1965 with respect to any contract entered into under this section to provide nursing home care of veterans, the payment of wages not less than those specified in section 6(b) of the Fair Labor Standards Act of 1938, as amended, shall be deemed to constitute compliance with such provisions.

(d) Subject to subsection (b) of this section, the Administrator may authorize for any veteran requiring nursing home care (1) for a service-connected disability, or (2) *in the discretion of the Administrator in accordance with the priorities described in section 612(i), for a non-service-connected disability*, direct admission for such care at the expense of the United States to any public or private institution not under the jurisdiction of the Administrator which furnishes nursing home care. Such admission may be authorized upon determination of need therefor by a physician employed by the Veterans' Administration or, in areas where no such physician is available, carrying out such function under contract or fee arrangement based on an examination by such physician. The amount which may be paid for such care and the length of care available under this subsection shall be the same as authorized under subsection (a) of this section.

(e) *For the purposes of this section, the term "nursing home care" includes intermediate care, as determined by the Administrator in accordance with regulations which the Administrator shall prescribe. The cost of intermediate care for purposes of payment by the United States pursuant to subsection (a)(ii) of this section shall be determined by the Administrator except that the rate of reimbursement shall be commensurately less than that provided for nursing home care (as defined in section 101(28) of this title).*

§ 620A. *Treatment and rehabilitation for alcoholism*

(a) *The Congress hereby finds and declares that alcoholism and alcohol abuse are among the most pervasive untreated diseases and disabilities afflicting the Nation, including the veteran population, and that the onset of alcoholism and alcohol abuse often occurs during military service.*

(b) *In order to meet the situation described in subsection (a) of this section, the Administrator, in carrying out the responsibilities to furnish hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, shall carry out specialized medical programs providing inpatient treatment (including treatment of the symptoms of detoxification), outpatient treatment, and rehabilitative services on a nationwide basis to eligible veterans suffering from the disability of alcoholism or alcohol abuse. In carrying out such specialized medical programs, the Administrator (1) shall utilize the most efficacious available treatment and rehabilitation modalities (stressing the utilization in such programs of counselors who are recovered alcoholics, half-way houses, and encounter-style therapeutic communities) extending beyond the detoxification period and designed to provide for the full recovery of the patient and the restoration of such patient to society as a productive, self-sufficient citizen, and (2) may utilize private half-way-house facilities for which the Administrator contracts in accordance with such regulations which the Administrator shall prescribe. Under the circumstances described in the last sentence of section 672(b) of this title, the Administrator shall arrange for the provision of treatment and rehabilitative services, at Veterans' Administration expense, in approved community facilities for which the Administrator contracts to veterans suffering from the disability of alcoholism or alcohol abuse.*

(c) *The Administrator shall submit annually (as a part of the annual report submitted pursuant to section 214 of this title) a full report on the programs carried out under this section, including the same type of information specified in section 667 of this title.*

Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

§ 621. Power to make rules and regulations

The Administrator shall prescribe—

(1) such rules and procedure governing the furnishing of hospital, nursing home, and domiciliary care as [he] the Administrator may deem proper and necessary;

(2) limitations in connection with the furnishing of hospital, nursing home, and domiciliary care; and

(3) such rules and regulations as [he] the Administrator deems necessary in order to promote good conduct on the part of persons who are receiving hospital, nursing home, or domiciliary care in Veterans' Administration facilities.

§ 622. Statement under oath

(a) For the purposes of section [610(a)(1)] 610(a)(1)(B), section 610(b)(2), section 624(c), and section [632(b)] 632(a)(2) of this

title, the statement under oath of an applicant on such form as may be prescribed by the Administrator shall be accepted as sufficient evidence of inability to defray necessary expenses.

(b) Notwithstanding the provisions of subsection (a) of this section, the receipt of pension under any law administered by the Veterans' Administration shall constitute sufficient evidence of inability to defray necessary expenses, and any veteran in receipt of such pension shall be exempt from making any statement under oath regarding [his] *such veteran's* inability to defray necessary expenses.

§ 623. Furnishing of clothing

The Administrator shall not furnish clothing to persons who are in Veterans' Administration facilities, except (1) where the furnishing of such clothing to indigent persons is necessary to protect health or sanitation, and (2) where [he] *the Administrator* furnishes veterans with special clothing made necessary by the wearing of prosthetic appliances.

§ 624. Hospital care, medical services and nursing home care abroad

(a) Except as provided in subsections (b) and (c), the Administrator shall not furnish hospital or domiciliary care or medical services outside any State.

(b) The Administrator may furnish necessary hospital care and medical services to any [otherwise eligible] veteran for any service-connected disability if the veteran (1) is a citizen of the United States sojourning or residing abroad, or (2) is in the Republic of the Philippines.

(c) Within the limits of those facilities of the Veterans Memorial Hospital at Manila, Republic of the Philippines, for which the Administrator may contract, [he] *the Administrator* may furnish necessary hospital care to a veteran [of any war] for any non-service-connected disability if such veteran is unable to defray the expenses of necessary hospital care. The Administrator may enter into contracts to carry out this section.

(d) The Administrator may furnish nursing home care, on the same terms and conditions set forth in section 620(a) of this title and at the same rate as specified in section 632(a) (4) of this title, to any veteran who has been furnished hospital care in the Philippines pursuant to this section, but who requires a protracted period of nursing home care.

§ 626. Reimbursement for loss of personal effects by natural disaster

The Administrator shall, under regulations which [he] *the Administrator* shall prescribe, reimburse veterans in Veterans' Administration hospitals and domiciliaries for any loss of personal effects sustained by fire, earthquake, or other natural disaster while such effects were stored in designated locations in Veterans' Administration hospitals or domiciliaries.

§ 627. Persons eligible under prior law

Persons who have a status which would, under the laws in effect on December 31, [1958] 1957, entitle them to the medical services, hospital and domiciliary care, and other benefits, provided for in this

chapter, but who did not meet the service requirements contained in this chapter, shall be entitled to such benefits notwithstanding failure to meet such service requirements.

§ 628. Reimbursement of certain medical expenses

(a) The Administrator may, under such regulations as [he] *the Administrator* shall prescribe, reimburse veterans entitled to hospital care or medical services under this chapter for the reasonable value of such care or services (including necessary travel), for which such veterans have made payment, from sources other than the Veterans' Administration, where—

(1) such care or services were rendered in a medical emergency of such nature that [they] *delay* would have been hazardous to life or health;

(2) such care or services were rendered to a veteran in need thereof (A) for an adjudicated service-connected disability, (B) for a non-service-connected disability associated with and held to be aggravating a service-connected disability, (C) for any disability of a veteran who has a total disability permanent in nature from a service-connected disability, or (D) for any illness, injury, or dental condition in the case of a veteran who is found to be (i) in need of vocational rehabilitation under chapter 31 of this title and for whom an objective had been selected or (ii) pursuing a course of vocational rehabilitation training and is medically determined to have been in need of care or treatment to make possible [his] *such veteran's* entrance into a course of training, or prevent interruption of a course of training, or hasten the return to a course of training which was interrupted because of such illness, injury, or dental condition; and

(3) Veterans' Administration or other Federal facilities were not feasibly available, and an attempt to use them beforehand would not have been reasonable, sound, wise, or practical.

(b) In any case where reimbursement would be in order under subsection (a) of this section, the Administrator may, in lieu of reimbursing such veteran, make payment of the reasonable value of care or services directly—

(1) to the hospital or other health facility furnishing the care or services; or

(2) to the person or organization making such expenditure on behalf of such veteran.

Subchapter IV—Hospital and Medical Care for Commonwealth of the Philippines Army Veterans

* * * * *

§ 632. Contracts and grants to provide hospital care, medical services and nursing home care

(a) The President, with the concurrence of the Republic of the Philippines, may authorize the Administrator to enter into a contract with the Veterans Memorial Hospital, with the approval of the appropriate department of the Government of the Republic of the Philippines, covering the period beginning on July 1, 1973, and ending on June 30, 1978, under which the United States—

(1) will pay for hospital care in the Republic of the Philippines, or for medical services which shall be provided either in the Veterans Memorial Hospital, or by contract, or otherwise by the Administrator in accordance with the conditions and limitations applicable generally to beneficiaries under section 612 of this title, for Commonwealth Army veterans and for new Philippine Scouts determined by the Administrator to be in need of such hospital care or medical services for service-connected disabilities;

(2) will pay for hospital care at the Veterans Memorial Hospital for Commonwealth Army veterans, and for new Philippine Scouts if they enlisted before July 4, 1946, determined by the Administrator to need such care for non-service-connected disabilities if they are unable to defray the expenses of necessary hospital care;

(3) may provide for the payment of travel expenses pursuant to section 111 of this title for Commonwealth Army veterans and new Philippine Scouts in connection with hospital care or medical services furnished them;

(4) may provide for payments for nursing home care, on the same terms and conditions as set forth in section 620(a) of this title, for any Commonwealth Army veteran or new Philippine Scout determined to need such care at a per diem rate not to exceed 50 per centum of the hospital per diem rate established pursuant to clause (6) of this subsection;

(5) may provide that payments for hospital care and for medical services provided to Commonwealth Army veterans and new Philippine Scouts or to United States veterans may consist in whole or in part of available medicines, medical supplies, and equipment furnished by the Administrator to the Veterans Memorial Hospital at valuations therefor as determined by the Administrator, who may furnish through the revolving supply fund, pursuant to section 5011 of this title, such medicines, medical supplies, and equipment as necessary for this purpose and to use therefore, as applicable, appropriations available for such payments;

(6) will provide for payments for such hospital care at a per diem rate to be jointly determined for each fiscal year by the two Governments to be fair and reasonable; and

(7) may stop payments under any such contract upon reasonable notice as stipulated by the contract if the Republic of the Philippines and the Veterans Memorial Hospital fail to maintain such hospital in a well-equipped and effective operating condition, as determined by the Administrator.

(b) The total of the payments authorized by subsection (a) of this section shall not exceed \$2,000,000 for any one fiscal year ending before July 1, 1978, which shall include an amount not to exceed \$250,000 for any one such fiscal year for the purposes of clause (4) of such subsection.

(c) The contract authorized by subsection (a) of this section may provide for the use by the Republic of the Philippines of beds, equipment, and other facilities of the Veterans Memorial Hospital at Manila, not required for hospital care of Commonwealth Army veterans

of new Philippine Scouts for service-connected disabilities, for hospital care of other persons in the discretion of the Republic of the Philippines except that (1) priority of admission and retention in such hospital shall be accorded Commonwealth Army veterans and new Philippine Scouts needing hospital care for service-connected disabilities, and (2) such use shall not preclude the use of available facilities in such hospital on a contract basis for hospital care or medical services for persons eligible therefor from the Veterans' Administration.

(d) To further assure the effective care and treatment of patients in the Veterans Memorial Hospital, there is authorized to be appropriated for each fiscal year during the five years beginning July 1, 1973, and ending June 30, 1978—

(1) the sum of \$50,000 to be used by the Administrator for making grants to the Veterans Memorial Hospital for the purpose of education and training of health service personnel who are assigned to such hospital; and

(2) the sum of \$50,000 to be used by the Administrator for making grants to the Veterans Memorial Hospital for the purpose of assisting the Republic of the Philippines in the replacement and upgrading of equipment and in rehabilitating the physical plants and facilities of such hospital.

Such grants shall be made on such terms and conditions as prescribed by the Administrator, including approval by [him] *the Administrator* of all education and training programs conducted by the hospital under such grants. Any appropriation made for carrying out the purposes of clause (2) of this subsection shall remain available until expended.

§ 633. Supervision of program by the President

The President, or any officer of the United States to whom [he] *the President* may delegate [his] authority under this section, may from time to time prescribe such rules and regulations and impose such conditions on the receipt of financial aid as may be necessary to carry out this subchapter.

* * * * *

Subchapter V—Payments to State Homes

§ 641. Criteria for payment

The Administrator shall pay each State at the per diem rate of—

- (1) \$4.50 for domiciliary care.
- (2) \$6 for nursing home care, and
- (3) \$10 for hospital care.

for each veteran [of any war or of service after January 31, 1955] receiving such care in a State home, if, in the case of such a veteran receiving domiciliary or hospital care, such veteran is eligible for such care in a Veterans' Administration facility, or if, in the case of such a veteran receiving nursing home care, such veteran meets the requirements of paragraph (1), (2), or (3) of section 610(a) of this title, except that the requirements of clause (B) of such paragraph (1) shall for this purpose refer to the inability to defray the expenses of necessary nursing home care; however, in no case shall the pay-

ments made with respect to any veteran under this section exceed one-half of the cost of the veteran's care in such State home]. No payment shall be made with respect to any veteran under this section in excess of one-half of the cost of the veteran's care in such State home. For the purposes of this section and consistent with the limitation in the preceding sentence, the Administrator shall apply the definition of nursing home care set forth in section 5031 (5) of this title with respect to determining the rate of per diem payable for any veteran receiving care in a State home in any State described in such section.

§ 642. Inspections of such homes; restrictions on beneficiaries

(a) The Administrator may inspect any State home at such times as [he] the Administrator deems necessary. No payment or grant may be made to any home under this subchapter unless such home is determined by the Administrator to meet such standards as the Administrator shall prescribe, which standards with respect to nursing home care shall be no less stringent than those prescribed pursuant to section 620 (b) of this title.

(b) The Administrator may ascertain the number of persons on account of whom payments may be made under this subchapter on account of any State home, but shall have no authority over the management or control of any State home.

§ 643. Applications

Payments on account of any veteran [of any war] cared for in a State home shall be made under this subchapter only from the date the Administrator receives a request for determination of such veteran's eligibility; however, if such request is received by the Administrator within ten days after care of such veteran begins, payments shall be made on account of such veteran from the date care began.

* * * * *

Subchapter VII—Preventive Health Care Program

§ 660. Purpose

The purpose of this subchapter is to provide for a preventive health care program under which the Administrator (1) shall attempt to ensure the best possible health care for veterans with service-connected disabilities by furnishing them feasible and appropriate preventive health care services, and (2) may, in connection therewith, carry out a pilot program (including research) on a geographical or other basis to determine the cost-effectiveness and medical advantages of furnishing preventive health care services to veterans with service-connected disabilities.

§ 661. Definition

For the purposes of this subchapter, the term "preventive health care services" may include, but is not limited to, periodic medical and dental examinations; patient health education (including nutrition education); maintenance of drug use profiles, patient drug monitoring, and drug utilization education; mental health preventive services (including family counseling); substance (including tobacco) abuse prevention measures; immunizations against infectious disease; pre-

vention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature; genetic counseling concerning inheritance of genetically determined diseases; routine vision testing and eye care services; periodic re-examination of likely target population (high-risk groups) for selected diseases and for functional decline of sensory organs, together with attendant appropriate remedial intervention; and such other medical services as may be necessary for providing effective and economical preventive health care.

§ 662. Preventive health care services; pilot program

(a) (1) *The Administrator, in accordance with regulations which the Administrator shall prescribe, may furnish, on an inpatient, outpatient, or ambulatory basis, nationally or geographically, such preventive health care services as the Administrator determines are feasible and appropriate to any veteran in connection with the treatment of a service-connected disability under this chapter and to any veteran described in section 612(f) (2) of this title.*

(2) *In connection with preventive health care services unfurnished under paragraph (1) of this subsection, the Administrator, in accordance with regulations which the Administrator shall prescribe, may institute appropriate controls and carry out followup studies (including research) to demonstrate the medical advantages and cost-effectiveness of furnishing such preventive health care services.*

(b) (1) *The Administrator shall provide for the planning, design, and conduct of a health maintenance pilot program to demonstrate the medical advantages and cost-effectiveness of furnishing, in accordance with the priorities specified in section 612(i) of this title, comprehensive preventive health care services to veterans with service-connected disabilities. Such pilot program shall be undertaken as a controlled scientifically valid study involving not to exceed 10,000 veterans (including control groups) and shall be initiated on October 1, 1977.*

(2) *The Administrator may not furnish comprehensive preventive health care services under paragraph (1) of this subsection after the last day of the tenth fiscal year following the fiscal year in which the pilot program is initiated.*

(c) *In carrying out the preventive health care program provided for in this subchapter, the Administrator shall emphasize the utilization of interdisciplinary health care teams composed, to the maximum extent feasible, of various professional and paraprofessional personnel, such as public health nurses, psychologists, optometrists, technicians, physician assistants, and expanded-function dental auxiliaries.*

(d) *In order to assist the Secretary of Health, Education, and Welfare in carrying out national immunization programs pursuant to other provisions of law, the Administrator may authorize the administration of immunizations to eligible veterans in connection with the provision of care for a disability under this chapter in any Veterans' Administration health care facility, utilizing vaccine furnished by the Secretary at no cost to the Veterans' Administration, and for such purpose, notwithstanding any other provision of law, the Secretary is authorized to provide such vaccine to the Veterans' Administration at no cost and the provisions of section 4116 of this title shall apply to*

claims alleging negligence or malpractice on the part of Veterans' Administration personnel granted immunity under such section.

§ 663. Reports

The Administrator shall include in the annual report to the Congress required by section 214 of this title a comprehensive report on the administration of this subchapter, including such recommendations for additional legislation as the Administrator deems necessary.

Subchapter VIII—Special Medical Treatment and Rehabilitative Services for Drug Dependence or Drug Abuse Disabilities

§ 671. Definition

As used in this subchapter and notwithstanding any other provision of this title, the term "veteran" includes (except as otherwise provided in section 3103 of this title) a person who served in the active military, naval, or air service and who was discharged or released therefrom with other than a dishonorable discharge.

§ 672. Treatment and rehabilitative services for veterans suffering from drug dependence or drug abuse disabilities

(a) *The Administrator shall furnish to any veteran with a drug dependence or drug abuse disability such special medical treatment and rehabilitative services and such hospital, nursing home, and domiciliary care (hereinafter in this subchapter collectively referred to as treatment and rehabilitative services) as the Administrator finds to be reasonably necessary to bring about the veteran's recovery and rehabilitation from such disability.*

(b) *Such treatment and rehabilitative services—*

(1) *shall (A) include, but not be limited to, in addition to those services described in section 601 of this title, individual counseling and referral services and crisis intervention, and (B) be provided in hospital, domiciliary, outpatient, and half-way-house and other community-based facilities (including satellite facilities located in areas where large numbers of veterans eligible for treatment and rehabilitative services under this subchapter reside) over which the Administrator has direct jurisdiction; and*

(2) *may be provided in private half-way-house facilities for which the Administrator contracts in accordance with such regulations as the Administrator shall prescribe.*

If the Administrator determines that it is essential to the successful treatment and rehabilitation of a veteran receiving initial evaluation or treatment under this subchapter or section 620A of this title that treatment and rehabilitative services (involving the furnishing of medication) be furnished in the same program to a member of the veteran's immediate family who is suffering from a drug or alcohol abuse or dependence disability, then the Administrator shall offer the veteran the provision of, and provide if requested, like treatment and services, at Veterans' Administration expense (up to costs deemed reasonable by the Administrator), in community facility, approved by the Administrator, for which the Administrator contracts and at which

such family member has been accepted for treatment (not at Veterans' Administrator expense) with the veteran.

(c) In providing for treatment and rehabilitative services under this subchapter to any veteran, the Administrator shall offer alternative modalities of treatment based upon the individual needs of such veteran.

(d) In contracting for treatment and rehabilitative services in facilities outside the Veterans' Administration pursuant to this subchapter, the Administrator shall, wherever feasible, give priority to community-based, multiple-modality, treatment and rehabilitation programs which employ peer group veterans and stress outreach efforts to identify and counsel veterans eligible for treatment and rehabilitative services under this subchapter.

(e) The Administrator shall, upon receipt of application for treatment and rehabilitative services under this subchapter by any veteran who has been discharged or released from a period of active military, naval, or air service, with other than an honorable or general discharge—

(1) advise such veteran of the right to apply to the appropriate military, naval, or air service for a review of the nature of such discharge or release for the purpose of correcting the nature of such discharge and thus removing any ineligibility to the receipt of benefits under this title or any other law;

(2) advise such veteran of the policy of the Armed Forces with respect to review of the nature of any discharge received in connection with drug use or possession; and

(3) advise such veteran of all program benefits under this title and any other law to which such veteran is entitled or would be entitled with a general or honorable discharge.

The Administrator shall offer and, if requested, provide to any veteran within the purview of this subsection such assistance as may be necessary to facilitate the process of preparing and filing an application for a review of the nature of such veteran's discharge or release from a period of active military, naval, or air service.

(f) (1) The Administrator shall also provide for treatment and rehabilitative services in the case of any veteran eligible therefor under this subchapter who has been charged with, or convicted of, a criminal offense by any court of competent jurisdiction in the United States, who is not confined and who is not required to participate in the treatment and rehabilitation program by any such court.

(2) The Administrator may also provide for treatment and rehabilitative services to any veteran eligible therefor under this subchapter who is under the jurisdiction of a court of competent jurisdiction as the result of having been charged with, or having been convicted of, a criminal offense and who is required to participate in a treatment and rehabilitation program by such court, but such services may be provided only under such conditions as the Administrator determines will ensure that the participation of such veteran in the program in question will not impair the voluntary nature of the treatment and rehabilitative services being provided to other patients in such program.

§ 673. Outreach and counseling

(a) *The Administrator shall utilize all available resources of the Veterans' Administration, including the use of peer-group veterans, in seeking out and counseling toward treatment and rehabilitation of all veterans, especially veterans who served after August 4, 1964, eligible for treatment and rehabilitative services under this subchapter.*

(b) *The Administrator shall take affirmative steps, in consultation with the Secretary of Labor and the Chairman of the Civil Service Commission, to (1) urge all Federal agencies, private and public firms, organizations, agencies, and persons to provide appropriate employment and training opportunities for veterans provided treatment and rehabilitative services under this subchapter and under section 620A of this title who have been determined by competent medical authority to be sufficiently rehabilitated to be employable, and (2) provide all possible assistance to the Secretary of Labor in placing such veterans in such opportunities.*

§ 674. Audits by Comptroller General

(a) *The Comptroller General of the United States, or any duly authorized representative thereof, shall have access for the purpose of audit and examination to any books, accounts, records, reports, files, and all other things or property of facilities outside the Veterans' Administration that are pertinent to payments received pursuant to contracts entered into under this subchapter.*

(b) *The Comptroller General shall carry out the responsibilities under this section in such a way as to comply with the provisions set forth in section 4132 of this title with respect to medical confidentiality.*

§ 675. Budget requests

For fiscal year 1977, and for each fiscal year thereafter, there shall be included in the budget required to be submitted to Congress pursuant to section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11), a separate line item showing the estimated expenditures by the Veterans' Administration under this subchapter and under section 620A of this title during such fiscal year for the treatment and rehabilitation of eligible veterans.

§ 676. Treatment of members of the Armed Forces by the Veterans' Administration

(a) *Any member of the active military, naval, or air service who is determined by the Secretary of the military department concerned to have a drug dependence or drug abuse disability, may, pursuant to such terms as may be agreed upon by the Secretary concerned and the Administrator, and subject to the provisions of the Act of March 4, 1915, as amended (31 U.S.C. 636), be transferred to any Veterans' Administration facility within the last thirty days of such member's tour of duty and be provided treatment and rehabilitative services under this subchapter as if such member were a veteran.*

(b) *The Administrator shall from time to time make a report to the Secretary concerned as to the progress of the treatment of any member transferred pursuant to the provisions of this section, and the Administrator shall release such member to the Secretary concerned when the Administrator finds that the drug abuse disability of such member is stabilized, or certifies that (1) such member refuses to comply with the*

terms and conditions of the treatment prescribed, or (2) the treatment which could otherwise be provided will be of no further benefit to such member.

(c) No member of the active military, naval, or air service shall be transferred to any Veterans' Administration facility pursuant to subsection (a) of this section unless such member requests such transfer in writing for a specified period of time within such member's tour of duty. No such member thereafter transferred shall be retained for treatment by the Administrator beyond such specified period of time within such member's tour of duty unless the member requests in writing treatment for a further specified period of time and such request is approved by the Secretary concerned and the Administrator.

§ 677. Reports

Not later than six months after the date of the enactment of this section and thereafter on May 1 of each year, the Administrator shall submit to the appropriate committees of the House of Representatives and the Senate a full report (covering the period since any prior report under this section) on the implementation of this subchapter and section 620A of this title separately with respect to alcoholism and alcohol abuse, on the one hand, and to drug dependency and abuse on the other, and an evaluation of the effectiveness of alternate treatment and rehabilitation programs provided hereunder and under such section 620A, including (1) the number of veterans and servicemen provided treatment and/or rehabilitative services, (2) the average duration of such treatment and/or services, (3) the estimated percentage of successful rehabilitation and enduring recovery cases, (4) an analysis of successful and unsuccessful rehabilitation experience, (5) a description of outreach, information dissemination, and job development and placement efforts, (6) a full accounting of payments to, and an evaluation of services and programs provided in, facilities outside the Veterans' Administration, (7) experience under the medical confidentiality provisions in section 4132 of this title, (8) plans for new program directions, and (9) such recommendations for legislation as the Administrator deems appropriate.

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CHAPTER 23—BURIAL BENEFITS

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§ 903. Death in Veterans' Administration facility; plot allowance

(a) Where death occurs in a Veterans' Administration facility to which the deceased was properly admitted for hospital, *nursing home*, or domiciliary care under section 610 or 611(a) of this title, the Administrator—

(1) shall pay the actual cost (not to exceed \$250) of the burial and funeral or, within such limits, may make contracts for such services without regard to the laws requiring advertisement for proposals for supplies and services for the Veterans' Administration; and

(2) shall, when such a death occurs in a State, transport the body to the place of burial in the same or any other State.

(b) In addition to the foregoing, if such a veteran, or a veteran

eligible for a burial allowance under section 902 of this title, is not buried in a national cemetery or other cemetery under the jurisdiction of the United States, the Administrator, in his discretion, having due regard for the circumstances in each case, may pay a sum not exceeding \$150, as a plot or interment allowance to such person as he prescribes. In any case where any part of the plot or interment expenses have been paid or assumed by a State, any agency or political subdivision of a State, or the employer of the deceased veteran, no claim for such allowance shall be allowed for more than the difference between the entire amount of the expenses incurred and the amount paid or assumed by any or all of the foregoing entities.

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PART III—READJUSTMENT AND RELATED BENEFITS

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Chapter 39.—AUTOMOBILES AND ADAPTIVE EQUIPMENT FOR CERTAIN DISABLED VETERANS AND MEMBERS OF THE ARMED FORCES

Sec.

1901. Definitions.

1902. Assistance for providing automobile and adaptive equipment.

1903. Limitations on assistance; special training courses.

1904. Research and development [; coordination with other Federal programs].

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§ 1903. Limitations on assistance; special training courses

(a) No eligible person shall be entitled to receive more than one automobile or other conveyance under the provisions of this chapter, and no payment shall be made under this chapter for the repair, maintenance, or replacement of an automobile or other conveyance.

(b) Except as provided in subsection (d) of section 1902 of this title, no eligible person shall be provided an automobile or other conveyance under this chapter until it is established to the satisfaction of the Administrator, in accordance with regulations he shall prescribe, that the eligible person will be able to operate the automobile or other conveyance in a manner consistent with his own safety and the safety of others and will satisfy the applicable standards of licensure to operate the automobile or other conveyance established by the State of his residency or other proper licensing authority.

(c) An eligible person shall not be entitled to adaptive equipment under this chapter for more than one automobile or other conveyance at any one time.

(d) Adaptive equipment shall not be provided under this chapter unless it conforms to minimum standards of safety and quality prescribed by the Administrator.

(e) (1) The Administrator shall provide, directly or by contract, for the conduct of special driver training courses at every hospital and, where appropriate, at regional offices and other medical facilities, of the Veterans' Administration to instruct such eligible person to operate the type of automobile or other conveyance such person wishes

to obtain with assistance under this chapter, and may make such courses available to any veteran [or member of the Armed Forces] eligible for care under chapter 17 of this title *or member of the Armed Forces*, who is determined by the Administrator to need the special training provided in such courses even though such veteran or member is not eligible for the assistance provided under this chapter.

(2) The Administrator is authorized to obtain insurance on automobiles and other conveyances (not owned by the Government) used in conducting the special driver training courses provided under this subsection and to obtain, at Government expense, personal liability and property damage insurance for all persons taking such courses without regard to whether such persons are taking the course on an in-patient or out-patient basis.

(3) *Notwithstanding any other provision of law, the Administrator may obtain, by purchase, lease, gift, or otherwise, any automobile, motor vehicle, or other conveyance deemed necessary to carry out the purposes of this subsection, and may sell, assign, transfer, or convey any such automobile, vehicle, or conveyance to which the Veterans' Administration obtains title for such price and upon such terms as the Administrator deems appropriate; and any proceeds received from any such disposition shall be credited to the applicable Veterans' Administration appropriation.*

§ 1904. Research and development [; coordination with other Federal programs]

(a) In carrying out [prosthetic and orthopedic appliance research under section 216 and medical research] *medical and prosthetic research* under section 4101 of this title, the Administrator, through the Chief Medical Director, shall provide for special emphasis on the research and development of adaptive equipment and adapted conveyances (including vans) meeting standards of safety and quality prescribed under subsection (d) of section 1903, including support for the production and distribution of devices and conveyances so developed.

(b) In carrying out subsection (a) of this section, the Administrator, through the Chief Medical Director, shall consult and cooperate with the Secretary of Health, Education, and Welfare and the Commissioner of the Rehabilitation Services Administration, Department of Health, Education, and Welfare, in connection with programs carried out under section 3(b) of the Rehabilitation Act of 1973 (Public Law 93-112; 87 Stat. 357) (relating to the development and support, and the stimulation of the development and utilization, including production and distribution of new and existing devices, of innovative methods of applying advanced medical technology, scientific achievement, and psychological and social knowledge to solve rehabilitation problems), section 202(b)(2) of such Act (relating to the establishment and support of Rehabilitation Engineering Research Centers), and section 405 of such Act (relating to the Secretarial responsibilities for planning, analysis, promoting utilization of scientific advances, and information clearinghouse activities).

PART IV—GENERAL ADMINISTRATIVE PROVISIONS

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CHAPTER 57—RECORDS AND INVESTIGATIONS

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Subchapter I—Records

§ 3301. Confidential nature of claims

(a) All files, records, reports, and other papers and documents pertaining to any claim under any of the laws administered by the Veteran's Administration and the names and addresses of present or former personnel of the armed services, and their dependents, in the possession of the Veterans' Administration shall be confidential and privileged, and no disclosure thereof shall be made except as provided in this section.

(b) The Administrator shall make disclosure of such files, records, reports, and other papers and documents as are described in subsection (a) this section as follows:

(1) To a claimant or [his] duly authorized agent or representative of a claimant as to matters concerning [himself] the claimant alone when, in the judgment of the Administrator, such disclosure would not be injurious to the physical or mental health of the claimant and to an independent medical expert or experts for an advisory opinion pursuant to section 4009 of this title.

(2) When required by process of a United States court to be produced in any suit or proceeding therein pending.

(3) When required by any department or other agency of the United States Government.

(4) In all proceedings in the nature of an inquest into the mental competency of a claimant.

(5) In any suit or other judicial proceeding when in the judgment of the Administrator such disclosure is deemed necessary and proper.

(c) The amount of pension, compensation, or dependency and indemnity compensation of any beneficiary shall be made known to any person who applies for such information, and the Administrator, with the approval of the President, upon determination that the public interest warrants or requires, may, at any time and in any manner, publish any or all information of record pertaining to any claim.

(d) The Administrator [in his] as a matter of discretion may authorize an inspection of Veterans' Administration records by duly authorized representatives of recognized organizations.

(e) Except as otherwise specifically provided in this section with respect to certain information, the Administrator may release information, statistics, or reports to individuals or organizations when in [his] the Administrator's judgment such release would serve a useful purpose.

(f) The Administrator may, pursuant to regulations the Administrator shall prescribe, release the names or addresses, or both, of any

present or former members of the Armed Forces, and/or their dependents, (1) to any nonprofit organization if the release is directly connected with the conduct of programs and the utilization of benefits under this title, or (2) to any criminal or civil law enforcement governmental agency or instrumentality charged under applicable law with the protection of the public health or safety if a qualified representative of such agency or instrumentality has made a written request that such names or addresses be provided for a purpose authorized by law. Any organization or member thereof or other person who, knowing that the use of any name or address released by the Administrator pursuant to the preceding sentence is limited to the purpose specified in such sentence, willfully uses such name or address for a purpose other than those so specified, shall be guilty of a misdemeanor and be fined not more than \$5,000 in the case of a first offense and not more than \$20,000 in the case of any subsequent offense.

(g) Any disclosure made pursuant to this section shall be made in accordance with the provisions of section 552a of title 5.

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PART V—BOARDS AND DEPARTMENTS

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CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

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SUBCHAPTER III—PROTECTION OF PATIENT RIGHTS

Sec.

4131. *Informed consent.*

4132. *Confidentiality of certain medical records.*

4133. *Nondiscrimination in the admission of alcohol and drug abusers to Veterans' Administration health care facilities.*

4134. *Coordination; reports.*

Subchapter I—Organization; General

§ 4101. Functions of Department

(a) There shall be in the Veterans' Administration a Department of Medicine and Surgery under a Chief Medical Director. The *primary* function[s] of the Department of Medicine and Surgery shall be [those necessary for] *to provide* a complete medical and hospital service, [including medical research,] *as provided in this title and in regulations* prescribed by the Administrator pursuant [to this chapter and other statutory authority,] *thereto*, for the medical care and treatment of veterans.

(b) In order to carry out more effectively the primary function of the Department of Medicine and Surgery [to provide a complete medical and hospital service for the medical care and treatment of veterans] and in order to assist in providing an adequate supply of health manpower to the Nation, the Administrator shall, to the extent feasible without interfering with the medical care and treatment of veterans, develop and carry out a program of education and training of such health manpower (including the developing and evaluating of new health careers, interdisciplinary approaches and career ad-

vancement opportunities), and shall carry out a major program for recruitment, training, and employment of veterans with medical military occupation specialties as [physicians'] physician assistants, [dentists' assistants], *expanded-function dental auxiliaries* and other medical technicians (including advising all such qualified veterans and [servicemen] *members of the armed forces* about to be discharged or released from active duty of such employment opportunities), acting in cooperation with such schools of medicine, osteopathy, dentistry, nursing, pharmacy, optometry, podiatry, public health, or allied health professions; other institutions of higher learning; medical centers; academic health centers; hospitals, and such other public or nonprofit agencies, institutions, or organizations as the Administrator deems appropriate.

(c) (1) *In order to carry out more effectively the primary function of the Department of Medicine and Surgery and in order to contribute to the Nation's knowledge about disease and disability, the Administrator shall, in connection with the provision of medical care and treatment to veterans, carry out a program of medical research (including biomedical, prosthetic, and health care services research, and stressing research into spinal cord injuries and diseases and other disabilities that lead to the paralysis of the lower extremities). In carrying out such research program, the Administrator shall act in cooperation with the entities described in subsection (b) of this section.*

(2) *Prosthetic research shall include research and testing in the field of prosthetic, orthotic, and orthopedic appliances and sensory devices. In order that the unique investigative material and research data in the possession of the Government may result in the improvement of such appliances and devices for all disabled persons, the Administrator, through the Chief Medical Director, shall make the results of such research available to any person, and shall consult and cooperate with the Secretary of Health, Education, and Welfare and the Commissioner of the Rehabilitation Services Administration, Department of Health, Education, and Welfare, in connection with programs carried out under section 3(b) of the Rehabilitation Act of 1973 (Public Law 93-112; 87 Stat. 357) (relating to the development and support, and the stimulation of the development and utilization, including production and distribution of new and existing devices, of innovative methods of applying advanced medical technology, scientific achievement, and psychological and social knowledge to solve rehabilitation problems), section 202(b) (2) of such Act (relating to the establishment and support of Rehabilitation Engineering Research Centers), and section 405 of such Act (relating to the secretarial responsibilities for planning, analysis, promoting utilization of scientific advances, and information clearinghouse activities).*

(3) (A) *With the approval of the Administrator, any contract for research authorized by this section, the performance of which involves a risk of an unusually hazardous nature, may provide that the United States will indemnify the contractor against either or both of the following, but only to the extent that they arise out of the direct performance of the contract and to the extent not covered by the financial protection required under subparagraph (E) of this paragraph:*

(i) *Liability (including reasonable expenses of litigation or*

settlement) to third persons, except liability under State or Federal workers' injury compensation laws to employees of the contractor employed at the site of and in connection with the contract for which indemnification is granted, for death, bodily injury, or loss of or damage to property, from a risk that the contract defines as unusually hazardous.

(ii) Loss of or damage to property of the contractor from a risk that the contract defines as unusually hazardous.

(B) A contract that provides for indemnification in accordance with subparagraph (A) of this paragraph must also provide for—

(i) notice to the United States of any claim or suit against the contractor for death, bodily injury, or loss of or damage to property; and

(ii) control of or assistance in the defense by the United States, at its election, of any such suit or claim for which indemnification is provided hereunder.

(C) No payment may be made under subparagraph (A) of this paragraph unless the Administrator, or the Administrator's designee, certifies that the amount is just and reasonable.

(D) Upon approval by the Administrator, payments under subparagraph (A) of this paragraph may be made from—

(i) funds obligated for the performance of the contract concerned;

(ii) funds available for research or development or both, and not otherwise obligated; or

(iii) funds appropriated for those payments.

(E) Each contractor which is a party to an indemnification agreement under subparagraph (A) of this paragraph shall have and maintain financial protection of such type and in such amounts as the Administrator shall require to cover liability to third persons and loss of or damage to the contractor's property. The amount of financial protection required shall be the maximum amount of insurance available from private sources, except that the Administrator may establish a lesser amount, taking into consideration the cost and terms of private insurance. Such financial protection may include private insurance, private contractual indemnities, self-insurance, other proof of financial responsibility, or a combination of such measures.

(F) In administering the provisions of this paragraph, the Administrator may use the facilities and services of private insurance organizations, and may contract to pay a reasonable compensation therefor. Any contract made under the provisions of this paragraph may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5), upon a showing by the Administrator that advertising is not reasonably practicable, and advance payments may be made under any such contract.

(G) The authority to indemnify contractors under this paragraph does not create any rights in third persons which would not otherwise exist by law.

(H) As used in this section, the term "contractor" includes subcontractors of any tier under a contract containing an indemnification provision pursuant to subparagraph (A) of this paragraph.

(4) Funds appropriated to carry out this subsection shall remain available until expended.

[(c)](d) (1) Within ninety days after enactment of this subsection, the Administrator, in consultation with the Chief Medical Director, is directed to conclude negotiations for an agreement with the National Academy of Sciences under which such Academy (utilizing its full resources and expertise) will conduct an extensive review and appraisal of personnel and other resource requirements in Veterans' Administration hospitals, clinics, and other medical facilities to determine a basis for the optimum numbers and categories of such personnel and other resources needed to insure the provision to eligible veterans of high quality care in all hospital, medical, domiciliary, and nursing home facilities. Such agreement shall provide that (A) at the earliest feasible date interim reports and the final report will be submitted by the National Academy of Sciences to the Administrator, the President of the Senate, and the Speaker of the House of Representatives, and (B) the final report will be submitted no later than twenty-four months after the date of the agreement except that the Administrator, in consultation with the Chief Medical Director and after consultation with the House and Senate Committees on Veterans' Affairs, may permit an extension up to twelve additional months.

(2) Within ninety days after the submission of the final report described in subsection (a) of this section, the Administrator shall submit to the Senate and House Committees on Veterans' Affairs a detailed report of [his] *the Administrator's* views on the National Academy of Sciences' findings and recommendations submitted in such report, including (A) the steps and timetable therefor (to be carried out in not less than three years) [he] *the Administrator* proposes to take to implement such findings and recommendations and (B) any disagreements, and the reasons therefor, with respect to such findings and recommendations.

(3) The Administrator shall cooperate fully with the National Academy of Sciences, and make available to the Academy all such staff, information, records, and other assistance, and shall set aside for such purposes such sums, as are necessary to insure the success of the study.

§ 4102. Divisions of Department

The Department of Medicine and Surgery shall include the following: Office of the Chief Medical Director, a Medical Service, a Dental Service, *a Podiatric Service, an Optometric Service*, a Nursing Service, and such other professional and auxiliary services as the Administrator may find to be necessary to carry out the functions of the Department.

§ 4103. Office of the Chief Medical Director

(a) The Office of the Chief Medical Director shall consist of the following—

(1) The Chief Medical Director, who shall be the Chief of the Department of Medicine and Surgery and shall be directly responsible to the Administrator for the operations of the Department [He], *and who* shall be a qualified doctor of medicine, appointed by the Administrator.

(2) The Deputy Chief Medical Director, who shall be the principal assistant of the Chief Medical Director [He], *and who* shall be a qualified doctor of medicine, appointed by the Administrator *upon the recommendation of the Chief Medical Director.*

(3) The Associate Deputy Chief Medical Director, who shall be an assistant to the Chief Medical Director and the Deputy Chief Medical Director [. He], *and who shall be a qualified doctor of medicine, appointed by the Administrator upon the recommendation of the Chief Medical Director.*

(4) Not to exceed eight Assistant Chief Medical Directors, who shall be appointed by the Administrator upon the recommendation[s] of the Chief Medical Director. Not more than two Assistant Chief Medical Directors may be [individuals] *persons* qualified in the administration of health services who are not doctors of medicine, dental surgery, or dental medicines. One Assistant Chief Medical Director shall be a qualified doctor of dental surgery or dental medicine who shall be directly responsible to the Chief Medical Director for the operation of the Dental Service.

(5) Such Medical Directors as may be appointed by the Administrator, upon the recommendation of the Chief Medical Director, to suit the needs of the Department. A Medical Director shall be either a qualified doctor of medicine or a qualified doctor of dental surgery or dental medicine.

(6) A Director of Nursing Service, who shall be a qualified registered nurse, appointed by the Administrator, and who shall be responsible to the Chief Medical Director for the operation of the Nursing Service.

(7) A Director of Pharmacy Service, a Director of Dietetic Service, [and a Director of Optometry, appointed by the Administrator] *a Director of Podiatric Service, and a Director of Optometric Service, appointed by the Administrator, and who shall be responsible to the Chief Medical Director for the operation of their respective Services.*

(8) Such other personnel [and employees] as may be authorized by this chapter.

(b) Except as provided in subsection (c) of this section—

(1) any appointment under this section shall be for a period of four years, with reappointment permissible for successive like periods,

(2) any such appointment or reappointment may be extended by the Administrator for a period not in excess of three years, and

(3) any person so appointed or reappointed, *or whose appointment or reappointment is extended* shall be subject to removal by the Administrator for cause.

(c) The Administrator may designate a member of the Chaplain Service of the Veterans' Administration as Director, Chaplain Service, for a period of two years, subject to removal by the Administrator for cause. Redesignation under this subsection may be made for successive like periods, *or for any period not exceeding two years.* [An individual] *A person* designated as Director, Chaplain Service, shall at the end of [his] *such person's* period of service as Director revert to the position, grade, and status which [he] *such person* held immediately prior to being designated Director, Chaplain Service, and all service as Director, Chaplain Service, shall be creditable as service in the former position.

§ 4104. Additional appointments

There shall be appointed by the Administrator additional personnel as [he] *the Administrator* may find necessary for the medical care of veterans, as follows:

(1) Physicians, dentists, *podiatrists*, *optometrists*, nurses, [physicians] *physician* assistants, and expanded-[duty] *function* dental auxiliaries;

(2) Pharmacists, physical therapists, occupational therapists, dietitians, and other scientific and professional personnel, such as [optometrists,] bacteriologists, chemists, biostatisticians, and medical and dental technologists.

§ 4105. Qualifications of appointees

(a) Any person to be eligible for appointment to the following positions in the Department of Medicine and Surgery must have the applicable qualifications:

(1) Physicians—

hold the degree of doctor of medicine or of doctor of osteopathy from a college or university approved by the Administrator, have completed an internship satisfactory to the Administrator, and be licensed to practice medicine, surgery, or osteopathy in a State;

(2) Dentist—

hold the degree of doctor of dental surgery or dental medicine from a college or university approved by the Administrator, and be licensed to practice dentistry in a State;

(3) Nurse—

have successfully completed a full course of nursing in a recognized school of nursing, approved by the Administrator, and be registered as a graduate nurse in a State;

(4) Director of a hospital, domiciliary, center or outpatient clinic—

have such business and administrative experience and qualifications as the Administrator shall prescribe;

(5) *Podiatrist*—

hold the degree of doctor of podiatric medicine, or its equivalent, from a school of podiatric medicine approved by the Administrator, and be licensed to practice podiatry in a State;

[(5)] (6) *Optometrist*—

hold the degree of doctor of optometry, or its equivalent, from a school of optometry approved by the Administrator and be licensed to practice optometry in a State;

[(6)] (7) *Pharmacist*—

hold the degree of bachelor of science in pharmacy, or its equivalent, from a school of pharmacy, approved by the Administrator, and be registered as a pharmacist in a State;

[(7)] (8) Physical therapist, occupational therapist, dietitians, and other [employees] *personnel* shall have such scientific or technical qualifications as the Administrator shall prescribe.

[(8)] (9) [Physicians] *Physician* assistants and expanded-[duty] *function* dental auxiliaries shall have such medical or dental and technical qualifications and experience as the Administrator shall prescribe.

(b) Except as provided in section 4114 of this title, no person may be appointed in the Department of Medicine and Surgery as a physician, dentist, nurse, [physicians'] *physician* assistant, or expanded [duty] *function* dental auxiliary unless such person is a citizen of the United States.

§ 4106. Period of appointments; promotions

(a) Appointments of physicians, dentists, *podiatrists*, *optometrists*, and nurses shall be made only after qualifications have been satisfactorily established in accordance with regulations prescribed by the Administrator, without regard to civil-service requirements.

(b) (1) [Such appointments as described in subsection (a) of this] *Appointments under section 4104(1) of this title* shall be for a probationary period of [three years] *two years*, and the record of each person serving under *any* such appointment [in the Medical, Dental, Podiatric, Optometric, and Nursing Services shall be reviewed from time to time by a board, appointed in accordance with regulations of the Administrator, and if said board shall find him not fully qualified and satisfactory he shall be separated from the services] *shall be reviewed periodically by a board composed of employees appointed under this chapter, whose grades are comparable to or higher than the grade of the employee being reviewed, selected in accordance with regulations which the Administrator shall prescribe. If such board finds any probationary employee not fully qualified and satisfactory for reasons relating to professional competence or performance, such employee's probationary appointment may be terminated, such employee may be reassigned, or such employee may be subject to other nondisciplinary action consistent with continuing the employment of such employee in a capacity in which such employee can effectively function, in accordance with the procedures prescribed in paragraphs (2) and (3) of this subsection.*

(2) When it is proposed to take any action described in the second sentence of paragraph (1) of this subsection with respect to a probationary employee, such employee shall be entitled, before any such action is taken to (A) a statement in writing of the reasons therefor and of any proposed finding with respect to professional competence or performance, (B) an opportunity to reply orally or in writing, or both, and (C) the assistance of any person of the employee's choice (not at Government expense) with regard to such reply.

(3) If a board recommends that any action described in the second sentence of paragraph (1) of this subsection be taken, any such action shall be taken in accordance with the procedures prescribed in section 4110(e) of this title.

(4) When it is proposed to take disciplinary action against a probationary employee on grounds which constitute misconduct or would result in stigma, such employee shall be entitled, before any such action is taken, to the disciplinary board procedures prescribed in section 4110 of this title.

(c) Promotions of physicians, dentists, *podiatrists*, *optometrists*, and nurses shall be made only after examination given in accordance with regulations prescribed by the Administrator. Advancement within grade may be made in increments of the minimum *rate of basic*

pay of the grade in accordance with regulations prescribed by the Administrator.

(d) In determining eligibility for reinstatement in Federal civil service of persons appointed to positions in the Department of Medicine and Surgery, who at the time of appointment shall have a civil-service status, and whose employment in the Department of Medicine and Surgery is terminated, the period of service performed in the Department of Medicine and Surgery shall be included in computing the period of service under applicable civil-service rules and regulations.

(e) In accordance with regulations prescribed by the Administrator, the grade [level and salary] and *annual rate of basic pay* of a physician, dentists, *podiatrist, optometrist*, or nurse changed from a level of assignment where the grade level is based on both the nature of the assignment and personal qualifications, may be adjusted to the grade [and salary] and *annual rate of basic pay* otherwise appropriate.

(f) The provisions of this section shall apply to [physicians'] *physician* assistants and expanded-[duty] *function* dental auxiliaries.

§ 4107. Grades and pay scales

(a) The [per annum full-pay scale or ranges] *annual rates or ranges of rates of basic pay* for positions provided in section 4103 of this title shall be as follows:

SECTION 4103 SCHEDULE

Chief Medical Director, \$54,000.

Deputy Chief Medical Director, \$52,000.

Associate Deputy Chief Medical Director, \$50,000.

Assistant Chief Medical Director, \$48,654.

Medical Director, \$42,066 minimum to \$47,674 maximum.

Director of Nursing Service, \$42,066 minimum to \$47,674 maximum.

Director of Podiatric Service, \$36,338 minimum to \$46,026 maximum.

Director of Chaplain Service, \$36,338 minimum to \$46,026 maximum.

Director of Pharmacy Service, \$36,338 minimum to \$46,026 maximum.

Director of Dietetic Service, \$36,338 minimum to \$46,026 maximum.

Director of [Optometry] *Optometric Service*, \$36,338 minimum to \$46,026 maximum.

(b) (1) The grades and [per annum full-pay ranges] *annual ranges of rates of basic pay* for positions provided in paragraph (1) of section 4104 of this title shall be as follows:

PHYSICIAN AND DENTIST SCHEDULE

Director grade, \$36,338 minimum to \$46,026 maximum.

Executive grade, \$33,736 minimum to \$43,861 maximum.

Chief grade, \$31,309 minimum to \$40,705 maximum.

Senior grade, \$26,861 minimum to \$34,916 maximum.
 Intermediate grade, \$22,906 minimum to \$29,782 maximum.
 Full grade, \$19,386 minimum to \$25,200 maximum.
 Associate grade, \$16,255 minimum to \$21,133 maximum.

NURSE SCHEDULE

Director grade, \$31,309 minimum to \$40,705 maximum.
 Assistant Director grade, \$26,861 minimum to \$34,916 maximum.
 Chief grade, \$22,906 minimum to \$29,782 maximum.
 Senior grade, \$19,386 minimum to \$25,200 maximum.
 Intermediate grade, \$16,255 minimum to \$21,133 maximum.
 Full grade, \$13,482 minimum to \$17,523 maximum.
 Associate grade, \$11,623 minimum to \$15,106 maximum.
 Junior grade, \$9,946 minimum to \$12,934 maximum.

CLINICAL PODIATRIST AND OPTOMETRIST SCHEDULE

Chief grade, \$31,309 minimum to \$40,705 maximum.
Senior grade, \$26,861 minimum to \$34,916 maximum.
Intermediate grade, \$22,906 minimum to \$29,782 maximum.
Full grade, \$19,386 minimum to \$25,200 maximum.
Associate grade, \$16,255 minimum to \$21,133 maximum.

(2) No person may hold the director grade in the "Physician and Dentist Schedule" unless [he] *such person* is serving as a director of a hospital, domiciliary, center, or outpatient clinic (independent). No person may hold the executive grade unless [he] *such person* holds the position of chief of staff at a hospital, center, or outpatient clinic (independent), or comparable position.

(c) Notwithstanding any other provision of law, the per annum salary rate of each [individual] *person* serving as a director of a hospital, domiciliary *facility*, or center who is not a physician shall not be less than the salary rate which [he] *such person* would receive under this section if [his] *such person's* service as a director of a hospital, domiciliary *facility*, or center had been service as a physician in the director grade. The position of the director of a hospital, domiciliary *facility*, or center shall not be subject to chapter 51 and subchapter III of chapter 53 of title 5.

(d) Notwithstanding any other provision of law, and except as provided in section 4118 of this title, pay may not be paid at a rate in excess of the rate of basic pay for an appropriate level authorized by sections 5314, 5315, or 5316 of title 5 for positions in the Executive Schedule, as follows:

- (1) Level III for the Chief Medical Director;
- (2) Level IV for the Deputy Chief Medical Director; and
- (3) Level V for all other positions for which such basic pay is paid under this section.

(e) (1) In addition to the [basic compensation] *rate of basic pay* provided for nurses in subsection (b) (1) of this section, a nurse shall receive additional [compensation] *pay* as provided by paragraphs (2) through (8) of this subsection.

(2) A nurse performing service on a tour of duty, any part of which is within the period commencing at 6 postmeridian and ending at 6

antemeridian, shall receive additional [compensation] *pay* for each hour of service on such tour at a rate equal to 10 per centum of the [employee's] *nurse's* [basic hourly rate] *hourly rate of basic pay*, if at least four hours of such tour fall between 6 postmeridian and 6 antemeridian. When less than four hours of such tour fall between 6 postmeridian and 6 antemeridian, the nurse shall be paid the differential for each hour of [work] *service* performed between those hours.

(3) A nurse performing service on a tour of duty, any part of which is within the period commencing at midnight Saturday and ending at midnight Sunday, shall receive additional [compensation] *pay* for each hour of service on such tour at a rate equal to 25 per centum of such nurse's [basic hourly rate] *hourly rate of basic pay*.

(4) A nurse performing service on a holiday designated by Federal statute or Executive order shall receive [such nurse's regular rate of basic pay, plus additional pay at a rate equal to such regular rate of basic pay, for that holiday work, including overtime work. Any service required to be performed by a nurse on such a designated holiday shall be deemed to be a minimum of two hours in duration] *for each hour of such service the nurse's hourly rate of basic pay, plus additional pay at a rate equal to such hourly rate of basic pay, for that holiday service, including overtime service.*

(5) A nurse performing officially ordered or approved hours of service in excess of forty hours in an administrative workweek, or in excess of eight hours in a day, shall receive overtime pay for each hour of such additional service; the overtime rates shall be one and one-half times such nurse's [basic hourly rate] *hourly rate of basic pay*, not to exceed one and one-half times the [basic hourly rate] *hourly rate of basic pay* for the minimum rate of Intermediate grade of the Nurse Schedule. For the purposes of this paragraph, overtime must be of at least fifteen minutes duration in a day to be creditable for overtime pay. Compensatory time off in lieu of pay for service performed under the provisions of this paragraph shall not be permitted, except as voluntarily requested in writing by the nurse in question. Any excess service performed under this paragraph on a day when service was not scheduled for such nurse, or for which such nurse is required to return to her place of employment, shall be deemed to be a minimum of two hours in duration.

(6) For the purpose of computing the additional [compensation] *pay* provided by paragraph (2), (3), (4), or (5) of this subsection, a nurse's [basic hourly rate] *hourly rate of basic pay* shall be derived by dividing such nurse's annual rate of basic [compensation] *pay* by two thousand and eighty.

(7) When a nurse is entitled to two or more forms of additional pay under paragraph (2), (3), (4), or (5) for the same period of [duty] *service*, the amounts of such additional pay shall be computed separately on the basis of such nurse's [basic hourly rate of pay] *hourly rate of basic pay*, except that no overtime pay as provided in paragraph (5) shall be payable for overtime service performed on a holiday designated by Federal statute or Executive order in addition to pay received under paragraph (4) for such service.

(8) A nurse who is officially scheduled to be on call outside such nurse's regular hours shall be [compensated] *paid* for each hour of such on-call duty, except for such time as such nurse may be called

back to work, at a rate equal to 10 per centum of the hourly rate for excess service as provided in paragraph (5) of this subsection.

(9) Any additional **[compensation]** *pay* paid pursuant to this subsection shall not be considered as basic **[compensation]** *pay* for the purposes of subchapter VI and section 5595 of subchapter IX of chapter 55, chapter 81, 83, or 87 of title 5, or other benefits based on basic **[compensation]** *pay*.

(f) Under standards which the Administrator shall prescribe in regulations, **[physicians']** *physician* assistants and expanded-**[duty]** *function* dental auxiliaries shall be compensated by use of Nurse Schedule grade titles and related pay ranges and shall be entitled to additional pay on the same basis as provided for nurses in paragraphs (2) through (8) of subsection (e) of this section.

(g) *When the Administrator finds such action to be necessary in order to obtain or retain the services of health care personnel to provide hospital care and medical services for veterans, the Administrator, notwithstanding any other provision of law, shall increase, on a nationwide basis the minimum or maximum rates of basic pay authorized under this chapter or title 5 for one or more grades or for one or more medical, dental, or health care fields within the grades, to (1) provide rates of basic pay commensurate with competitive pay practices in the same occupation or in order to achieve internal alignment of rates of basic pay within the Department of Medicine and Surgery, or (2) meet staffing requirements at Veterans' Administration facilities. Any such increase in the minimum rate of basic pay for any grade may not exceed the maximum rate prescribed pursuant to law for such grade. Any such increase in the maximum rate of basic pay for any grade may not exceed in corresponding amount, the rate provided for in the statutory range for that grade, subject to the limitation on the rate of basic pay fixed by administrative action set forth in section 5363 of title 5.*

§ 4108. Personnel administration

(a) Notwithstanding any law, Executive order, or regulation, the Administrator shall prescribe by regulation the hours and conditions of employment and leaves of absence of physicians, dentists, *podiatrists, optometrists*, nurses, **[physicians']** *physician* assistants, and expanded-**[duty]** *function* dental auxiliaries appointed to the Department of Medicine and Surgery, except that the hours of employment in carrying out responsibilities under this title of any physician, dentist, *podiatrist, optometrist* (other than an intern or resident appointed pursuant to section 4114 of this title), nurse, physicians' assistant, or expanded-**[duty]** *function* dental auxiliary appointed on a full-time basis who accepts responsibilities for carrying out professional services for remuneration other than those assigned under this title, shall consist of not less than eighty hours in a biweekly pay period (as that term is used in section 5504 of title 5), and no such person may—

(1) assume, responsibility for the medical care of any patient other than a patient admitted for treatment at a Veterans' Administration facility, except in those cases where the **[individual]** *person*, upon request and with the approval of the Chief Medical Director, assumes such responsibilities to assist communities or

medical practice groups to meet medical needs which would not otherwise be available for a period not to exceed one hundred and eighty calendar days, which may be extended by the Chief Medical Director for additional periods not to exceed one hundred and eighty calendar days each;

(2) teach or provide consultative services at any affiliated institution if such teaching or consultation will, because of its nature or duration, conflict with [his] *such person's* responsibilities under this title;

(3) accept payment under any insurance or assistance program established under subchapter XVIII, or XIX of chapter 7 of title 42, or under chapter 55 of title 10 for professional services rendered by [him] *such person* while carrying out [his] *such person's* responsibilities under this title;

(4) accept from any source, with respect to any travel performed by [him] *such person* in the course of carrying out [his] *such person's* responsibilities under this title, any payment or per diem for such travel, other than as provided for in section 4111 of title 5;

(5) request or permit any individual or organization to pay, on [his] *such person's* behalf, for insurance insuring [him] *such person* against malpractice claims arising in the course of carrying out [his] *such person's* responsibilities under this title or for [his] *such person's* dues or similar fees for membership in medical or dental societies or related professional associations, except where such payments constitute a part of [his] *such person's* remuneration for the performance of professional responsibilities permitted under this section, other than those carried out under this title; and

(6) perform, in the course of carrying out [his] *such person's* responsibilities under this title, professional services for the purpose of generating money for any fund or account which is maintained by an affiliated institution for the benefit of such institution, or for [his] *such person's* personal benefit, or both, and in the case of any such fund or account established before the effective date of this subsection—

(A) the affiliated institution shall submit semiannually an accounting to the Administrator and to the Comptroller General of the United States with respect to such fund or account, and thereafter shall maintain such fund or account subject to full public disclosure and audit by the Administrator and the Comptroller General for a period of three years or for such longer period as the Administrator shall prescribe, and

(B) no physician, dentist, *podiatrist*, *optometrist*, nurse, [physicians'] *physician* assistant, or expanded-[duty] *function* dental auxiliary may receive, after the effective date of this subsection, any cash from amounts deposited in such fund or account derived from services performed prior to the effective date of this subsection.

(b) As used in this section, the term "affiliated institution" means any medical school or other institution of higher learning with which the Administrator has a contract or agreement [pursuant to] *as re-*

ferred to in section 4112(b) of this title for the training or education of health manpower.

(c) As used in this section, the term "remuneration" means the receipt of any amount of monetary benefit from any non-Veterans' Administration source in payment for carrying out any professional responsibilities.

§ 4110. Disciplinary boards

[(a) The Chief Medical Director, under regulations prescribed by the Administrator shall from time to time appoint boards to be known as disciplinary boards, each such board to consist of not less than three nor more than five employees, senior in grade, of the Department of Medicine and Surgery, to determine, upon notice and fair hearing, charges of inaptitude, inefficiency, or misconduct of any person employed in a position provided in paragraph (1) of section 4104 of this title. When such charges concern a dentist, the majority of employees on the disciplinary board shall be dentists.

[(b) The Administrator shall appoint the chairman and secretary of the board, each of whom shall have authority to administer oaths.

[(c) The Chief Medical Director may designate or appoint one or more investigators, to assist each disciplinary board in the collection and presentation of evidence. Any person answering to charges before a disciplinary board may be represented by counsel of his own choosing.

[(d) A disciplinary board, when in its judgment charges are sustained, shall recommend to the Administrator suitable disciplinary action, within limitations prescribed by the Administrator, which shall include reprimand, suspension without pay, reduction in grade, and discharge from the Department of Medicine and Surgery of such person. The Administrator shall either approve the recommendation of the board, approve such recommendation with modification or exception, approve such recommendation and suspend further action at the time, or disapprove such recommendation. He shall cause to be executed such action as he approves. The decision of the Administrator shall be final.

[(e) The Administrator, within such limitations as he may prescribe, may delegate to the Chief Medical Director the authority vested in him by subsections (b) and (d) of this section to (1) appoint the chairman and secretary of a disciplinary board, such official to have the power prescribed by this section, and (2) receive and act upon the recommendations of such a board. Any person against whom disciplinary action is taken under authority delegated pursuant to this subsection shall have the right to appeal such action to the Administrator, but in the absence of such an appeal the decision of the Chief Medical Director shall have the same force and effect as a decision of the Administrator.]

(a) When it is proposed to take disciplinary action for such cause including inaptitude, ineffectiveness, or misconduct) as will promote the efficiency of the service against any person appointed under section 4104(1) of this title who has completed the probationary period provided for in section 4106(b) of this title, or when it is proposed to take disciplinary action on grounds which constitute misconduct or would result in stigma against an employee appointed under (or identified in) section 4104(1) of this title who has not completed such proba-

tionary period (including part-time, temporary full-time, and intermittent employees appointed under section 4114(a) and serving in positions identified in such section 4104(1) or a resident or intern appointed under section 4114(b) of this title, the Chief Medical Director shall cause to be appointed a disciplinary board. Such board shall hear and review charges on the basis of which disciplinary action is proposed and make findings and recommendations thereon, and shall operate in accordance with regulations which the Administrator shall prescribe, pursuant to the provisions of this section. No disciplinary action shall be taken against any such employee until a final agency decision on such proposed action has been made.

(b) Each such board shall consist of not less than three nor more than five employees appointed under this chapter, whose grades are comparable to or higher than the grade of the employee charged, and a majority of whom are of the same profession as such employee. The members of the board shall be selected by the Chief Medical Director in accordance with regulations which the Administrator shall prescribe.

(c) The Chief Medical Director shall appoint the chairman of the board who shall be a member of the same profession as the employee charged. A member of the board shall be elected as secretary by a majority of the board. The chairman and the secretary shall have authority to administer oaths to persons testifying before the board. The Chief Medical Director may designate or appoint one or more investigators to assist the board in the collection of evidence, and counsel may be designated to represent the Veterans' Administration.

(d) Any employee answering to charges before a disciplinary board shall be entitled to (1) specification of charges, (2) a full hearing with opportunity to produce supportive witnesses and confront and cross-examine available witnesses, and (3) representation by a person of the employee's choice (not at Government expense) throughout the procedure prescribed in this section.

(e) If a disciplinary board determines that any charge is sustained, it shall recommend to the Chief Medical Director such disciplinary action as it deems appropriate with respect to such charge, which may include, but is not limited to, reprimand, suspension without pay, reassignment, reduction in grade, and separation. The Chief Medical Director shall either (1) approve the findings and recommendation of the board, (2) approve such findings and recommendation with modification of the recommendation or exception to any finding, or (3) disagree with such findings and recommendation as to such charge. The Chief Medical Director shall make a final decision in writing on the matter under consideration (stating the reasons for such decision, for any modification of or disagreement with any board recommendation, and for any exception to any board finding), shall provide the employee with such written decision, and shall take appropriate action to effectuate such decision. In the event the Chief Medical Director proposes to take exception to a finding or modify a recommendation of the board, the Chief Medical Director may refer the matter to the board for reconsideration; if after such reconsideration by the board, the Chief Medical Director continues to take exception to any of its findings or to disagree with its recommendation, or both, the Chief Medical Director may make an independent review of the

record before making a final decision under this section. The decision of the Chief Medical Director shall be the final agency decision.

(f) The Chief Medical Director may, as disciplinary action under subsection (e) of this section, order the reassignment of any employee charged under this section. The Chief Medical Director may also reassign an employee for the good of the service and such reassignment shall not, in itself, entitle such employee to the disciplinary board procedures prescribed in this section. When such a reassignment for the good of the service would result in the reduction in grade, salary, or relative standing in the Department of Medicine and Surgery of an employee who has completed the probationary period prescribed by section 4106(b) of this title, such employee shall be entitled, before any such reassignment is effectuated, to the disciplinary board procedures prescribed in this section. When an employee alleges that a reassignment proposed for the good of the service is disciplinary in nature, the employee shall be entitled, before any such reassignment is effectuated, to attempt to sustain such allegation through the procedures prescribed by the Administrator to determine employee grievances. If such allegation is sustained in such grievance procedure, the employee shall be entitled, before any such disciplinary action is taken, to the disciplinary board procedures prescribed in this section. For the purposes of this section, the term "reassignment" means the transfer of an employee from one duty station to another or from one set of responsibilities to another, within the Department of Medicine and Surgery.

* * * * *

§ 4112. Special medical advisory group and other advisory bodies

(a) The Administrator shall establish a special medical advisory group composed of members of the medical, dental, *podiatric*, *optometric*, and allied scientific professions, nominated by the Chief Medical Director, whose duties shall be to advise the Administrator, through the Chief Medical Director, and the Chief Medical Director direct, relative to the care and treatment of disabled veterans, and other matters pertinent to the Department of Medicine and Surgery. The special medical advisory group shall meet on a regular basis as prescribed by the Administrator. The number, terms of service, [compensation] pay, and allowances to members of such advisory group shall be in accord with existing law and regulations.

(b) In each case where the Administrator has a contract or agreement with any school, institution of higher learning, medical center, hospital, or other public or nonprofit agency, institution, or organization, for the training or education of health service personnel, [he] the Administrator shall establish an advisory committee (that is, deans committee, medical advisory committee, or the like). Such advisory committee shall advise the Administrator and the Chief Medical Director with respect to policy matters arising in connection with, and the operation of, the program with respect to which it was appointed and may be established on an institutionwide, multidisciplinary basis or on a regional basis whenever such is found to be feasible. Members of each such advisory committee shall be appointed by the Administrator and shall include personnel of the Veterans' Administration and of the entity with which the Administrator has entered into such contract or agreement. The number of members and terms of

members of each advisory committee shall be prescribed by the Administrator.

§ 4113. Travel expenses of employees

The Administrator may pay the expenses, except membership fees [of employees], of persons described in section 4103, [paragraph (1) of section 4104] *section 4104(1)*, and physicians, dentists, *podiatrists*, *optometrists*, [and nurses] *nurses*, *physician assistants*, and *expanded-function dental auxiliaries* appointed on a temporary full-time or part-time basis under section 4114 of this title detailed by the Chief Medical Director to attend meetings of associations for the promotion of medical and related science.

§ 4114. Temporary full-time, part-time, and without compensation appointments; residencies and internships

(a) (1) The Administrator, upon the recommendation of the Chief Medical Director, may employ, without regard to civil service or classification laws, rules, or regulations—

(A) physicians, dentists, *podiatrists*, *optometrists*, nurses, *physician assistants*, *expanded-function dental auxiliaries*, dietitians, social workers, librarians, and other professional, clerical, technical, and unskilled personnel (including interns, residents, trainees, and students in medical support programs) on a temporary full-time, part-time, or without compensation basis; and

(B) physicians, dentists, *podiatrists*, *optometrists*, nurses, *physician assistants*, *expanded-function dental auxiliaries*, and other professional and technical personnel on a fee basis.

(2) Personnel employed under paragraph (1) of this subsection shall be in addition to personnel described in section 4103, paragraph (1) of section 4104, and section 4111 of this title and shall be paid such rates of pay as the Administrator may prescribe.

(3) (A) Temporary full-time appointments of physicians, dentists, *podiatrists*, *optometrists*, [and nurses] *nurses*, *physician assistants*, and *expanded-function dental auxiliaries* may exceed ninety days only if the Chief Medical Director finds that circumstances render it impracticable to obtain the necessary services through appointments under paragraph (1) of section 4104 of this title. Temporary full-time appointments of persons who have successfully completed a full course of nursing in a recognized school of nursing, approved by the Administrator, and are pending registration as a graduate nurse in a State, shall not exceed one year. Temporary full-time appointments of other personnel shall not exceed one year.

(B) No part-time appointment shall be for a period of more than one year, except for appointments of physicians, dentists, *podiatrists*, *optometrists*, [nurses and interns, and] *nurses*, *physician assistants*, *expanded-function dental auxiliaries*, and *interns*, resident and other trainees in medical support programs.

(b) (1) The Administrator shall have authority to establish residencies and internships; to appoint qualified persons to such positions without regard to civil-service or classification laws, rules, or regulations; and to prescribe the conditions of such employment, including necessary training, and the customary amount and terms of pay (*which may be established retroactively based on changes in such*

customary amount and terms) during the period of such employment and training.

(2) *In order to carry out the purposes of paragraph (1) of this subsection, the Chief Medical Director shall cause to be appointed, in accordance with regulations which the Administrator shall prescribe, House Staff Review Committees to review periodically the academic and professional performance and progress of persons appointed under paragraph (1) of this subsection. When it is proposed to take any action, such as reduction in grade, suspension without pay, or separation with respect to a person appointed under such paragraph for reasons relating to professional or academic competence or performance, such person shall be entitled, before any such action is taken, to (A) a statement in writing of the reasons therefor and of any proposed finding with respect to professional or academic competence or performance, and (B) an opportunity to reply orally or in writing, or both to the House Staff Review Committee. When it is proposed to taken any such action with respect to a person appointed under paragraph (1) of this subsection on grounds which constitute misconduct or would result in stigma, such person shall be entitled, before any such action is effectuated, to the disciplinary board procedures prescribed in section 4110 of this title.*

[(2)(3) For the purposes of this title, the term ["intern" shall include an internship or the equivalency thereof], "internship" shall include the equivalency of an internship as determined in accordance with regulations which the Administrator shall prescribe, and the term "intern" shall mean a person serving an internship.

[(3)(4) In order to carry out more efficiently the provisions of paragraph (1) of this subsection, the Administrator may contract with one or more hospitals, medical schools, or medical installations having hospital facilities and participating with the Veterans' Administration in the training of interns or residents to provide for the central administration of stipend payments, provision of fringe benefits, and maintenance of records for such interns and residents by the designation of one such institution to serve as a central administrative agency for this purpose. The Administrator may pay to such designated agency, without regard to any other law or regulation governing the expenditure of Government moneys either in advance or in arrears, an amount to cover the cost for the period such intern or resident serves in a Veterans' Administration hospital of (A) stipends fixed by the Administrator pursuant to paragraph (1) of this subsection, (B) hospitalization, medical care, and life insurance, and any other employee benefits as are agreed upon by the participating institutions for the period that such intern or resident serves in a Veterans' Administration hospital, (C) tax on employers pursuant to chapter 21 of the Internal Revenue Code of 1954, where applicable, and in addition, (D) an amount to cover a pro rata share of the cost of expense of such central administrative agency. Any amount paid by the Administrator to such central administrative agency to cover the cost of hospitalization, medical care, or life insurance or other employee benefits shall be in lieu of any benefits of like nature to which such intern or resident may be entitled under the provisions of title 5, and the acceptance of stipend and employee benefits from the designated central administrative agency shall constitute a waiver by the recipient

of any claim [he] *such recipient* might have to any payment of stipends or employee benefits to which [he] *such recipient* may be entitled under this title or title 5. Notwithstanding the foregoing, any period of service of any such intern or resident in a Veterans' Administration hospital shall be deemed creditable service for the purposes of section 8332 of title 5. The agreement may further provide that the designated central administrative agency shall make all appropriate deductions from the stipend of each intern and resident for local, State, and Federal taxes, maintain all records pertinent thereto and make proper deposits thereof, and shall maintain all records pertinent to the leave accrued by such intern and resident for the period during which [he] *such recipient* serves in a participating hospital, including a Veterans' Administration hospital. Such leave may be pooled, and the intern or resident may be afforded to leave by the hospital in which [he] *such person* is serving at the time the leave is to be used to the extent of [his] *such person's* total accumulated leave, whether or not earned at the hospital in which [he] *such person* is serving at the time the leave is to be afforded.

(c) When the Chief Medical Director determines that it is not possible to recruit qualified citizens for the necessary services, appointments under this section may be made without regard to the citizenship requirements of section 4105 of this title or of any other law prohibiting the employment of, or payment of compensation to, a person who is not a citizen of the United States.

(d) The Chief Medical Director may waive for the purpose of appointments under this section the requirements of section 4105(a) of this title that the licensure of a physician, [or] dentist, *podiatrist*, or *optometrist* or the registration of a nurse must be in a "State," if—

(1) in the case of a physician, [or] dentist, *podiatrist*, or *optometrist*, [he] *the person* is to be used on a research or an academic post or where there is no direct responsibility for the care of patients; or

(2) in any case, where the [individual] *person* is to serve in a country other than the United States and [his] *such person's* licensure or registration is in the country in which [he] *the person* is to serve.

(e) The program of training prescribed by the Administrator in order to qualify a person for the position of full-time physician's assistant or [dentist's assistance] *expanded-function dental auxiliary* shall be considered a full-time institution program for purposes of chapter 34 of this title. The Administrator may consider training for such a position to be on a less than full-time basis for purposes of such chapter when the combined classroom (and other formal instruction) portion of the program and the on-the-job training portion of the program total less than 30 hours per week.

* * * * *

§ 4116. Defense of certain malpractice and negligence suits

(a) The remedy—

(1) against the United States provided by sections 1346(b) and 2672 of title 28, or

(2) through proceedings for compensation or other benefits from the United States as provided by any other law, where the

availability of such benefits precludes a remedy under section 1346(b) or 2672 of title 28,

for damages for personal injury, including death, allegedly arising from malpractice or negligence of a physician, dentist, *podiatrist*, *optometrist*, nurse, [physicians'] *physician* assistant, [dentists' assistant] *expanded-function dental auxiliary*, pharmacist, or paramedical (for example, medical and dental technicians, nursing assistants, and therapists) or other supporting personnel in furnishing medical care or treatment while in the exercise of [his] *such person's* duties in or for the Department of Medicine and Surgery shall hereafter be exclusive of any other civil action or proceeding by reason of the same subject matter against such physician, dentist, *podiatrist*, *optometrist*, nurse, [physicians'] *physician* assistant, [dentists' assistant] *expanded-function dental auxiliary*, pharmacist, or paramedical or other supporting personnel (or [his] *such person's* estate) whose act or omission gave rise to such claims.

(b) The Attorney General shall defend any civil action or proceeding brought in any court against any person referred to in subsection (a) of this section (or [his] *such person's* estate) for any such damage or injury. Any such person, against whom such civil action or proceeding is brought shall deliver within such time after date of service or knowledge of service as determined by the Attorney General, all process served upon [him] *such person* or an attested true copy thereof to [his] *such person's* immediate superior or to whomever was designated by the Administrator to receive such papers and such person shall promptly furnish copies of the pleading and process therein to the United States attorney for the district embracing the place wherein the proceeding is brought, to the Attorney General, and to the Administrator.

(c) Upon a certification by the Attorney General that the defendant was acting in the scope of [his] *such person's* employment in or for the Department of Medicine and Surgery at the time of the incident out of which the suit arose, any such civil action or proceeding commenced in a State court shall be removed without bond at any time before trial by the Attorney General to the district court of the United States of the district and division embracing the place wherein it is pending and the proceeding deemed a tort action brought against the United States under the provisions of title 28 and all references thereto. After removal the United States shall have available all defenses to which it would have been entitled if the action had originally been commenced against the United States. Should a United States district court determine on a hearing on a motion to remand held before a trial on the merits that the employee whose act or omission gave rise to the suit was not acting within the scope of [his] *such person's* office or employment, the case shall be remanded to the State court.

(d) The Attorney General may compromise or settle any claim asserted in such civil action or proceeding in the manner provided in section 2677 of title 28, and with the same effect.

(e) The Administrator may, to the extent [he] *the Administrator* deems appropriate, hold harmless or provide liability insurance for any person to whom the immunity provisions of this section apply (as described in subsection (a) of this section), for damage for personal injury or death, or for property damage, negligently caused by

such person while furnishing medical care or treatment (including the conduct of clinical studies or investigations) in the exercise of [his] *such person's* duties in or for the Department of Medicine and Surgery, if such person is assigned to a foreign country, detailed to State or political division thereof, or is acting under any other circumstances which preclude the remedies of an injured third person against the United States, provided by sections 1346(b) and 2672 of title 28, for such damage or injury.

§ 4117. Contracts for scarce medical specialist services

The Administrator may enter into contracts with [medical schools,] *schools and colleges of medicine, osteopathy, dentistry, podiatry, optometry, and nursing, clinics, and any other group or individual capable of furnishing such services to provide scarce medical specialist services at Veterans' Administration facilities (including, but not limited to, services of physicians, dentists, podiatrists, optometrists, nurses, [physicians'] physician assistants, [dentists' assistants] expanded-function dental auxiliaries, technicians, and other medical support personnel).*

§ 4118. Special pay for physicians and dentists

(a) (1) Notwithstanding the provisions of section 4107(d) or any other provision of law, in order to recruit and retain highly qualified physicians and dentists *in professional or administrative positions or clinical research positions in the career development program* in the Department of Medicine and Surgery, the Administrator, pursuant to the provisions of this section and regulations which she shall prescribe hereunder, shall provide, in addition to any pay or allowance to which such physician or dentist is entitled, special pay in an amount not more than (A) \$13,500 per annum to any physician employed in the Department of Medicine and Surgery, or (B) \$6,750 per annum to any dentist so employed, except as provided in paragraphs (2) and (3) of this subsection, upon the execution, and for the duration of, a written agreement by such physician or dentist to complete a specified number of years of service in the Department.

(2) Special pay may not be paid under this section to any physician or dentist who—

(A) is employed on less than half-time or intermittent basis,

(B) occupies an internship or residency training position, or

(C) is a reemployed annuitant.

(3) The Chief Medical Director, pursuant to such regulations, may determine categories of *professional and administrative* positions applicable to both physicians and dentists in the Department of Medicine and Surgery as to which there is no significant recruitment and retention problem. Physicians and dentists serving in such positions shall not be eligible for special pay under this section.

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Subchapter II—Regional Medical Education Centers

§ 4121. Designation of Regional Medical Education Centers

(a) In carrying out [his] *the Administrator's* functions under section 4101 of this title with regard to the training of health manpower,

the Administrator shall implement a pilot program under which [he] *the Administrator* shall designate as Regional Medical Education Centers such Veterans' Administration hospitals as [he] *the Administrator* determines appropriate to carry out the provisions of this subchapter in geographically dispersed areas of the United States.

(b) Each Regional Medical Education Center (hereinafter in this subchapter referred to as "Center") designated under subsection (a) of this section shall provide in-residence continuing medical and related education programs for medical and health personnel eligible for training under this subchapter, including (1) the teaching of newly developed medical skills and the use of newly developed medical technologies and equipment, (2) advanced clinical instruction, (3) the opportunity for conducting clinical investigations, (4) clinical demonstrations in the utilization of new types of health personnel and in the better utilization of the skills of existing health personnel, and (5) routine verification of basic medical skills and, where determined necessary, remediation of any deficiency in such skills.

§ 4122. Supervision and staffing of Centers

(a) Centers shall be operated under the supervision of the Chief Medical Director and staffed with personnel qualified to provide the highest quality instruction and training in various medical and health care disciplines.

(b) As a means of providing appropriate recognition to [individuals] *persons* in the career service of the Department of Medicine and Surgery who possess outstanding qualifications in a particular medical or health care discipline, the Chief Medical Director shall from time to time and for such period as [he] *the Chief Medical Director* deems appropriate assign such [individuals] *persons* to serve as visiting instructors at Centers.

(c) Whenever [he] *the Chief Medical Director* deems it necessary for the effective conduct of the program provided for under this subchapter, the Chief Medical Director is authorized to contract for the services of highly qualified medical and health personnel from outside the Veterans' Administration to serve as instructors at such Centers.

§ 4123. Personnel eligible for training

The Chief Medical Director shall determine the manner in which personnel are to be selected for training in the Centers. Preference shall be given to career personnel of the Department of Medicine and Surgery. To the extent that facilities are available, other medical and health personnel shall, on a fully reimbursable basis, be eligible for in-residence training in the Centers. *Any proceeds to the Government received therefrom shall be credited to the applicable Veterans' Administration medical appropriation.*

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Subchapter III—Protection of Patient Rights

§ 4131. Informed consent

The Administrator, upon the recommendation of the Chief Medical Director and pursuant to the provisions of section 4134 of this title, shall prescribe regulations establishing procedures to ensure that all medical and prosthetic research carried out and, to the maximum extent

practicable, all patient care furnished under this title shall be carried out only with the full and informed consent of the patient or subject, in appropriate cases, a representative thereof.

§ 4132. Confidentiality of certain medical records

(a) Records of the identity, diagnosis, prognosis, or treatment of any patient or subject which are maintained in connection with the performance of any program or activity (including education, training, treatment, rehabilitation, or research) relating to drug abuse, alcohol or alcohol-abuse, or sickle-cell anemia which is carried out by or for the Veterans' Administration under this title shall, except as provided in subsection (e) of this section, be confidential and (section 3301 of this title to the contrary notwithstanding) such records may be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) (1) The content of any record referred to in subsection (a) of this section may be disclosed by the Administrator in accordance with the prior written consent of the patient or subject with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed by the Administrator pursuant to section 4134 of this title.

(2) Whether or not any patient or subject, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives written consent, the content of such record may be disclosed by the Administrator as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient or subject in any report of such research, audit, or evaluation, or otherwise disclose patient or subject identities in any manner.

(C) If authorized by an appropriate order of a United States court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient or subject, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(3) In the event that the patient or subject who is the subject of any record referred to in subsection (a) of this section is deceased, the content of any such record may be disclosed by the Administrator only upon the prior written request of the next of kin, executor, administrator, or other personal representative of such patient or subject and only if the Administrator determines that such disclosure is necessary for such survivor to obtain benefits to which such survivor may be entitled, including the pursuit of legal action, but then only to the extent, under such circumstances, and for such purposes as may be allowed in regulations prescribed pursuant to section 4134 of this title.

(c) Except as authorized by a court order granted under subsection

(b) (2) (C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against, or to conduct any investigation of, a patient or subject.

(d) The prohibitions of this section shall continue to apply to records concerning any person who has been a patient or subject, irrespective of whether or when such person ceases to be a patient.

(e) The prohibitions of this section shall not prevent any interchange of records—

(1) within and among those facilities of the Veterans' Administration furnishing health care to veterans, or

(2) between such facilities and the Armed Forces.

(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

§ 4133. Nondiscrimination in the admission of alcohol and drug abusers to Veterans' Administration health care facilities

Veterans eligible for treatment under chapter 17 of this title who are alcohol or drug abusers and who are suffering from medical disabilities shall not be discriminated against in admission or treatment, solely because of their alcohol or drug abuse or dependence, by any Veterans' Administration health care facility. The Administrator, pursuant to the provisions of section 4134 of this title, shall prescribe regulations for the enforcement of this nondiscrimination policy with respect to the admission and treatment of such eligible veterans who are alcohol or drug abusers.

§ 4134. Coordination; reports

(a) Regulations prescribed pursuant to section 4131 of this title, section 4132 of this title with respect to the confidentiality of alcohol and drug abuse medical records, and section 4133 of this title, shall, to the maximum extent feasible consistent with other provisions of this title, make applicable the regulations governing—

(1) human experimentation and informed consent prescribed by the Secretary of Health, Education, and Welfare, based on the recommendations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, established by section 201 of the National Research Act, as amended (Public Law 93-348; 88 Stat. 348), and

(2) (A) the confidentiality of drug and alcohol abuse medical records, and (B) the admission of drug and alcohol abusers to private and public hospitals, prescribed pursuant to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended (42 U.S.C. 4551 et seq.), and the Drug Abuse Office and Treatment Act of 1972, as amended (21 U.S.C. 1101 et seq.), to the conduct of research and to the provision of hospital care, nursing home care, domiciliary care, and medical services under this title. Such regulations may contain such definitions, and may provide for such safeguards and procedures (including procedures and criteria for the issuance and scope of court orders under section 4132 (b) (2) (C))

of this title) as are necessary to prevent circumvention or evasion thereof, or to facilitate compliance therewith. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary of Health, Education, and Welfare, and as appropriate, the Director of the Office of Drug Abuse Policy (or any successor authority), in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they and the Administrator prescribe.

(b) Not later than sixty days after the date of enactment of this subsection, the Administrator shall submit to the appropriate committees of the House of Representatives and the Senate a full report with respect to the regulations (including guidelines, policies, and procedures thereunder) prescribed pursuant to subsection (a) of this section. Such report shall include (1) an explanation of any inconsistency between such regulations and the regulations of the Secretary referred to in such subsection (a); (2) an account of the extent, substance, and results of consultations with the Secretary (or Director, as appropriate) respecting the prescribing and implementation of the Administrator's regulations; and (3) such recommendations for legislation and administrative actions as the Administrator determines are necessary and desirable. The Administrator shall timely publish such report in the Federal Register.

CHAPTER 75—VETERANS' CANTEEN SERVICE

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§ 4202. Duties of Administrator with respect to Service

The Administrator shall—

(1) establish, maintain, and operate canteens where deemed necessary and practicable at hospitals and homes of the Veterans' Administration and at other Veterans' Administration establishments where similar essential facilities are not reasonably available from outside commercial sources;

(2) establish, maintain, and operate such warehouses and storage depots as may be necessary in operating the canteens;

(3) furnish the Service for its use in connection with the establishment, maintenance, and operation thereof, such space, buildings, and structures under control of the Veterans' Administration as [he] the Administrator may consider necessary, including normal maintenance and repair service thereon. Reasonable charges, to be determined by the Administrator, shall be paid annually by the Service for the space, buildings, and structures so furnished, except that the Administrator may reduce or waive such charges whenever payment of such charges would impair the working capital required by the Service;

(4) transfer to the Service without charge, rental, or reimbursement such necessary equipment as may not be needed for other purposes, and furnish the Service such services and utilities, including light, water, and heat, as may be available and necessary for its use. Reasonable charges, to be determined by the Administrator, shall be paid annually by the Service for the utilities so furnished;

(5) employ such persons as are necessary for the establishment, maintenance, and operation of the Service, and pay the salaries, wages, and expenses of all such employees from the funds of the Service. Personnel necessary for the transaction of the business of the Service at canteens, warehouses, and storage depots shall be appointed, compensated from funds of the Service, and removed by the Administrator without regard to civil-service laws and the Classification Act of 1949. Such employees shall be subject to the Veterans' Preference Act of 1944, the Civil Service Retirement Act, and laws administered by the Bureau of Employees' Compensation applicable to civilian employees of the United States;

(6) make all necessary contracts or agreements to purchase or sell merchandise, fixtures, equipment, supplies, and services, without regard to section 5 of title 41, and to do all things necessary to carry out such contracts or agreements, including the making of necessary adjustments and compromising of claims in connection therewith;

(7) fix the prices of merchandise and services in canteens so as to carry out the purposes of this chapter;

(8) accept gifts and donations of merchandise, fixtures, equipment, and supplies for the use and benefit of the Service;

(9) make such rules and regulations, not inconsistent with the provisions of this chapter, as [he] *the Administrator* considers necessary or appropriate to effectuate its purposes;

(10) delegate such duties and powers to employees as [he] *the Administrator* considers necessary or appropriate, whose official acts performed within the scope of the delegated authority shall have the same force and effect as though performed by the Administrator;

(11) authorize the use of funds of the Service when available, subject to such regulations as [he] *the Administrator* may deem appropriate, and without regard to the provisions of sections 521 and 543 of title 31, for the purpose of cashing checks, money orders, and similar instruments in nominal amounts for the payment of money presented by veterans hospitalized or domiciled at hospitals and homes of the Veterans' Administration, and by other persons authorized by section 4203 of this title to make purchases at canteens. Such checks, money orders, and other similar instruments may be cashed outright or may be accepted, subject to strict administrative controls, in payment for merchandise or services, and the difference between the amount of the purchase and the amount of the tendered instrument refunded in cash.

* * * * *

§ 4204. Financing of Service

(a) To finance the establishment, maintenance, and operation of the Service there is hereby authorized to be appropriated, from time to time, such amounts as are necessary to provide for (1) the acquisition of necessary furniture, furnishings, fixtures, and equipment for the establishment, maintenance, and operation of canteens, warehouses, and storage depots; (2) stocks of merchandise and supplies for canteens and reserve stocks of same in warehouses and storage

depots; (3) salaries, wages, and expenses of all employees; (4) administrative and operation expenses; and (5) adequate working capital for each canteen and for the Service as a whole. Amounts appropriated under the authority contained in this chapter, amounts heretofore appropriated to carry out Public Law 636, Seventy-ninth Congress, and all income from canteen operations become and will be administered as a revolving fund to effectuate the provisions of this chapter.

(b) *Without regard to fiscal year limitations, obligations may be incurred against anticipated budgetary resources of the Service revolving fund in such amounts and for such periods as the Administrator may determine to be necessary to maintain and continue operations without incurring over-obligations at any time during the fiscal year.*

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§ 4206. Budget of Service

The Service shall prepare annually and submit a budget program as provided for wholly owned Government corporations by sections 841-849 of title 31, which shall contain an estimate of the needs of the Service for the ensuing *five* fiscal [year] years including an estimate of the amount required to restore any impairment of the revolving fund resulting from operations of the current fiscal year. Any balance in the revolving fund at the close of the fiscal year in excess of the estimated requirements for the ensuing *five* fiscal [year] years shall be covered into the Treasury as miscellaneous receipts. *In determining estimated requirements, the Service may provide for such capital improvements to canteen facilities, including those which are constructed and become a part of the building or structure, as may be approved by the Director of the Office of Management and Budget and included in the budget required to be submitted to Congress pursuant to section 201 of the Budget and Accounting Act, 1921 (31 U.S.C. 11).*

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

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SUBCHAPTER IV—SHARING OF MEDICAL FACILITIES, EQUIPMENT, AND INFORMATION

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Subchapter I—Provisions Relating to Hospitals and Homes

§ 5001. Hospital and domiciliary facilities

(a) (1) The Administrator, subject to the approval of the President, shall provide hospitals, domiciliaries, and out-patient dispensary facilities for veterans entitled under this title to hospital or domiciliary care or medical services. Such hospitals, domiciliaries, and other facilities may be provided by (A) purchase, replacement, or remodeling or extension of existing plants, or (B) construction of such facilities on sites already owned by the United States or on sites acquired by purchase, condemnation, gift, or otherwise.

(2) The Administrator, subject to the approval of the President, is authorized to establish and operate not less than one hundred and twenty-five thousand hospital beds in facilities over which the Administrator has direct [and exclusive] jurisdiction for the care and treatment of eligible veterans who are [tuberculosis] *tuberculous*, neuropsychiatric, medical, and surgical cases, and the Administrator shall staff and maintain, in such a manner as to insure the immediate acceptance and timely and complete care of patients, sufficient beds and other treatment capacities to accommodate, and provide such care to, eligible veterans applying for admission and found to be in need of hospital care or medical services. The Administrator shall maintain the bed and treatment capacities of all Veterans' Administration medical facilities so as to insure the accessibility and availability of such beds and treatment capacities to eligible veterans in all States and to minimize delays in admissions and in the provision of such care and of services pursuant to section 612 of this title. The Chief Medical Director shall periodically analyze agencywide admission policies and the records of those eligible veterans who apply for hospital care and medical services but are rejected or not immediately admitted or provided such care or services, and the Administrator shall annually advise the House and Senate Committees on Veterans' Affairs of the results of such analysis and the number of any additional beds and treatment capacities and the appropriate staffing and funds therefor found necessary to meet the needs of such veterans for such necessary care and services.

(3) The Administrator, subject to the approval of the President, shall establish and operate not less than [eight] *ten* thousand beds in [the] fiscal year [ending June 30, 1974] *1980* and in each fiscal year thereafter for the furnishing of nursing home care to eligible veterans in facilities over which the Administrator has direct [and exclusive] jurisdiction. The nursing beds authorized by this paragraph shall be in addition to the hospital beds provided for in paragraph (2) of this subsection.

(b) Hospitals, domiciliaries, and other medical facilities provided by the Administrator (including nursing home facilities for which the Administrator contracts under section 620 of this title) shall be of fire, earthquake, and other natural disaster resistant construction in accordance with standards which the Administrator shall prescribe on a State or regional basis after surveying appropriate State and local laws.

ordinances, and building codes and climatic and seismic conditions pertinent to each such facility. When an existing plant is purchased, it shall be remodeled to comply with the requirements stated in the first sentence of this subsection. In order to carry out this subsection, the Administrator shall appoint an Advisory Committee on Structural Safety of Veterans' Administration Facilities, on which shall serve at least one architect and one structural engineer expert in fire, earthquake, and other natural disaster resistance who shall not be employees of the Federal Government, to advise [him] *the Administrator* on all matters of structural safety in the construction and remodeling of Veterans' Administration facilities in accordance with the requirement of this subsection, and which shall approve regulations prescribed thereunder. The Associate Deputy Administrator, the Chief Medical Director, or [his] *the Chief Medical Director's* designee, and the Veterans' Administration official charged with the responsibility for construction shall be ex officio members of such committee.

(c) The location of each hospital or domiciliary and its nature (whether for domiciliary care or the treatment of tuberculosis, neuropsychiatric cases, or general medical and surgical cases) shall be within the discretion of the Administrator, subject to the approval of the President.

(d) The Administrator may accept gifts or donations for any of the purposes of this section.

(e) The Administrator, subject to the approval of the President, may use as hospitals, domiciliaries, or out-patient dispensary facilities such suitable buildings, structures, and grounds owned by the United States on March 3, 1925, as may be available for such purposes, and the President may by Executive order transfer any such buildings, structures, and grounds to the control and jurisdiction of the Veterans' Administration upon the request of the Administrator.

(f) As used in this section and in sections 5002 and 5003 of this title, the term "hospitals, domiciliaries, or out-patient dispensary facilities" includes necessary buildings and auxiliary structures, mechanical equipment, approach work, roads, and trackage facilities leading thereto, sidewalks abutting hospital reservations, vehicles, livestock, furniture, equipment, accessories, accommodations for officers, nurses, and attending personnel, and proper and suitable recreational facilities.

(g) The Administrator may make contributions to local authorities toward, or for, the construction of traffic controls, road improvements, or other devices adjacent to Veterans' Administration medical facilities when deemed necessary for safe ingress or egress.

§ 5002. Construction and repair of buildings

The construction of new hospitals, domiciliaries and out-patient dispensary facilities, or the replacement, extension, alteration, remodeling, or repair of all such facilities shall be done in such a manner as the President may determine. The President may require the architectural, engineering, constructing, or other forces of any of the departments of the Government to do or assist in such work, and [he] *the President* may employ individuals and agencies not connected with the Government, if in [his opinion] *the opinion of the President* such is desirable, at such compensation as he may consider reasonable.

§ 5004. Garages and parking facilities

(a) The Administrator may construct and maintain on reservations of Veterans' Administration hospitals and domiciliaries, garages for the accommodation of privately owned automobiles of employees of such hospitals and domiciliaries. Employees using such garages shall make such reimbursement therefor as the Administrator may deem reasonable.

(b) (1) The Administrator may establish, operate, and maintain, in conjunction with Veterans' Administration hospitals and domiciliaries, parking facilities for the accommodation of privately owned vehicles of Federal employees, and vehicles of visitors and other individuals having business at such hospitals and domiciliaries.

(2) The Administrator may establish and collect (or provide for the collection of) fees, for the use of the parking facilities, authorized by subsection (b) (1) of this section, at such rate or rates which [he] *the Administrator* determines would be reasonable under the particular circumstances; but no fee may be charged for the accommodation of any privately owned vehicle used in connection with the transportation of a veteran to or from such a hospital or domiciliary for the purpose of examination or treatment or in connection with a visit to a patient or member in such hospital or domiciliary.

(3) The Administrator may contract, by lease or otherwise, with responsible persons, firms or corporations, for the operation of such parking facilities, under such terms and conditions as [he] *the Administrator* may prescribe, and without regard to the laws concerning advertising for competitive bids.

(c) Money received from the use of the garages and from the parking facilities operations authorized by this section, may be credited to the applicable appropriation charged with the cost of operating and maintaining these facilities. Any amount not needed for the maintenance, operation, and repair of these facilities shall be covered into the Treasury of the United States as miscellaneous receipts.

§ 5005. Acceptance of certain property

The President may accept from any State or other political subdivision, or from any person, any building, structure, equipment, or grounds suitable for the care of the disabled, with due regard to fire or other hazards, state of repair, and all other pertinent considerations. [He] *The President* may designate which agency of the Federal Government shall have the control and management of any property so accepted.

* * * * *

§ 5007. Partial relinquishment of legislative jurisdiction

The Administrator, on behalf of the United States, may relinquish to the State in which any lands or interests therein under [his] *the Administrator's* supervision or control are situated, such measure of legislative jurisdiction over such lands or interests as is necessary to establish concurrent jurisdiction between the Federal Government and the State concerned. Such partial relinquishment of legislative jurisdiction shall be initiated by filing a notice thereof with the Governor of the State concerned, or in such other manner as may be prescribed by the laws of such State, and shall take effect upon acceptance by such State.

Subchapter II—Procurement and Supply

§ 5011. Revolving supply fund

(a) The revolving supply fund established for the operation and maintenance of a supply system for the Veterans' Administration (including procurement of supplies, equipment, and personal services and the repair and reclamation of used, spent, or excess personal property) shall be—

(1) available without fiscal year limitations for all expenses necessary for the operation and maintenance of such supply system;

(2) reimbursed from appropriations for the cost of all services, equipment, and supplies furnished, at rates determined by the Administrator on the basis of estimated or actual direct and indirect cost; and

(3) credited with advances from appropriations for activities to which services or supplies are to be furnished, and all other receipts resulting from the operation of the fund, including property returned to the supply system when no longer required by activities to which it had been furnished, the proceeds of disposal of scrap, excess or surplus personal property of the fund, and receipts from carriers and others for loss of or damage to personal property.

At the end of each fiscal year, any net income of the fund, after making provision for prior losses, shall be covered into the Treasury of the United States as miscellaneous receipts.

(b) An adequate system of accounts for the fund shall be maintained on the accrual method, and financial reports prepared on the basis of such accounts. An annual business type budget shall be prepared for operations under the fund.

(c) The Administrator is authorized to capitalize, at fair and reasonable values as determined by [him] *the Administrator*, all supplies and materials and depot stocks of equipment on hand or on order.

§ 5012. Authority to procure and dispose of property and to negotiate for common services

(a) The Administrator may lease for a term not exceeding three years lands or buildings, or parts or parcels thereof, belonging to the United States and under [his] *the Administrator's* control. Any lease made pursuant to this subsection to any public or nonprofit organization may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5). Notwithstanding section 321 of the Act entitled "An Act making appropriations for the legislative branch of the Government for the fiscal year ending June 30, 1933, and for other purposes", approved June 30, 1932 (40 U.S.C. 303b), or any other provision of law, a lease made pursuant to this subsection to any public or nonprofit organization may provide for the maintenance, protection, or restoration, by the lessee, of the property leased, as a part or all of the consideration for the lease. Prior to the execution of any such lease, the Administrator shall give appropriate public notice of [his] *the Administrator's* intention to do so in the newspaper of the community in which the lands or buildings to be leased are located. The proceeds from such leases, less expenses for maintenance,

operation, and repair of buildings leased for living quarters, shall be covered into the Treasury of the United States as miscellaneous receipts.

(b) The Administrator may, for the purpose of extending benefits to veterans and dependents, and to the extent [he] *the Administrator* deems necessary, procure the necessary space for administrative, clinical, medical, and outpatient treatment purposes by lease, purchase, or construction of buildings, or by condemnation or declaration of taking, pursuant to law.

(c) The Administrator may procure laundry services, and other common services as specifically approved by [him] *the Administrator* from nonprofit, tax-exempt educational, medical or community institutions, without regard to the requirements of section 302(c) of the Federal Property and Administrative Services Act of 1949, as amended (41 U.S.C. 252(c)), whenever such services are not reasonably available from private commercial sources. Notwithstanding this exclusion, the provisions of section 304 of that Act shall apply to procurement authorized by this subsection.

§ 5013. Procurement of prosthetic appliances

The Administrator may procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as [he] *the Administrator* may determine to be proper, without regard to any other provision of law.

§ 5014. Grant of easements in Government-owned lands

The Administrator, whenever [he] *the Administrator* deems it advantageous to the Government and upon such terms and conditions as [he] *the Administrator* deems advisable, may grant on behalf of the United States to any State, or any agency or political subdivision thereof, or to any public-service company, easements in and rights-of-way over lands belonging to the United States which are under [his] *the Administrator's* supervision and control. Such grant may include the use of such easements or rights-of-way by public utilities to the extent authorized and under the conditions imposed by the laws of such State relating to use of public highways. Such partial, concurrent, or exclusive jurisdiction over the areas covered by such easements or rights-of-way, as the Administrator deems necessary or desirable, is hereby ceded to the State in which the land is located. The Administrator may accept or secure on behalf of the United States from the State in which is situated any land conveyed in exchange for any such easement or right-of-way, such jurisdiction as [he] *the Administrator* may deem necessary or desirable over the land so acquired. Any such easement or right-of-way shall be terminated upon abandonment or nonuse of the same and all right, title, and interest in the land covered thereby shall thereupon revert to the United States or its assignee.

Subchapter III—State Home Facilities for Furnishing Nursing Home Care

§ 5031. Definitions

For the purpose of this subchapter—

[(a)] (1) The [war] veteran population of each State shall be

determined on the basis of the latest figures certified by the Department of Commerce.

[(b)] (2) The term "State" does not include any possession of the United States.

[(c)] (3) The term "construction" means the construction of new buildings, the expansion, remodeling, modification, or alteration of existing buildings (*including buildings not presently used for providing nursing home care*) and the providing of initial equipment for any such buildings.

[(d)] (4) The term "cost of construction" means the amount found by the Administrator to be necessary for a project of construction of nursing home care facilities, including architect fees, but not including the cost of acquisition of land.

(5) *The term "nursing home care" shall be deemed to include domiciliary care provided in any State in which no Veterans' Administration hospital or domiciliary facility is located.*

§ 5032. Declaration of purpose

The purpose of this subchapter is to assist the several States to construct State home facilities for furnishing nursing home care to [war] veterans.

* * * * *

§ 5034. General regulations

Within six months after the date of enactment of this [subchapter] section or any amendment to it with respect to such amendment, the Administrator shall prescribe the following by regulation:

(1) The number of beds required to provide adequate nursing home care to [war] veterans residing in each State, which number shall not exceed two and one-half beds per thousand [war] veteran population in the case of any State.

(2) General standards of construction, repairs, modernization, alteration, and equipment for facilities for furnishing nursing home care which are constructed with assistance received under this subchapter.

(3) *General standards for the furnishing of nursing home care in facilities which are constructed with assistance received under this subchapter, which standards shall be no less stringent than those standards prescribed by the Administrator pursuant to section 620(b) of this title, except that facilities constructed with assistance received under this subchapter pursuant to the definition in section 5031(5) of this title shall meet such standards as the Administrator shall prescribe. The Administrator may inspect any State facility constructed with assistance received under this subchapter at such times as the Administrator deems necessary to ensure that such facility meets such standards.*

§ 5035. Applications with respect to projects; payments

(a) After regulations have been prescribed by the Administrator under section 5034 of this title, any State desiring to receive assistance for a project for construction of State home facilities for furnishing nursing home care must submit to the Administrator an application. Such application shall set forth—

(1) the amount of the grant requested with respect to such

project which may not exceed 65 per centum of the estimated cost of construction of such project,

(2) a description of the site for such project,

(3) plans and specifications for such project in accordance with regulations prescribed by the Administrator pursuant to section 5034(2) of this title,

(4) reasonable assurance that upon completion of such project the facilities will be used principally to furnish nursing home care to [war] veterans and that not more than 10 per centum of the bed occupancy at any one time will consist of patients who are not receiving nursing home care as [war] veterans, *subject to the provisions of subsection (c) (1) of this section*,

(5) reasonable assurance that title to such site is or will be vested solely in the applicant, a State home, or another agency or instrumentality of the State,

(6) reasonable assurance that adequate financial support will be available for the construction of the project and for its maintenance and operation when complete,

(7) reasonable assurance that the State will make such reports in such form and containing such information as the Administrator may, from time to time reasonably require, and give the Administrator, upon demand, access to the records upon which such information is based, and

(8) reasonable assurance that the rates of pay for laborers and mechanics engaged in construction of the project will be not less than the prevailing local wage raise for similar work as determined in accordance with sections 276a through 276a-5 of title 40 (known as the Davis-Bacon Act).

(b) The Administrator shall approve any such application if [he] *the Administrator* finds that—

(1) there are sufficient funds available to make the grant requested with respect to such project,

(2) such grant does not exceed 65 per centum of the estimated cost of construction of such project,

(3) the application contains such reasonable assurance as to use, title, financial support, reports and access to records, and payment of prevailing rates of wages, as the Administrator may determine to be necessary, and

(4) the plans and specifications for such project are in accord with regulations prescribed pursuant to section 5034(2) of this title and that the construction of such project, together with other projects under construction and other facilities, will not result in more than the number of beds prescribed by the Administrator pursuant to section 5034(1) of this title for the State in which such project is located being available for furnishing nursing home care to [war] veterans in such State.

(c) *(1) The Administrator shall waive requirements set forth in subsection (a) (4) of this section in the case of an application from any State described in section 5031(5) of this title to the extent that such State provides reasonable assurance that the portion of the facility constructed with assistance received under this subchapter will be used principally for veterans and that not more than such proportion as the Administrator shall deem reasonable (not more than 50 per centum)*

of the bed occupancy at any one time will consist of patients who are not receiving care as veterans.

[(c)](2) No application submitted to the Administrator under this section shall be disapproved until the Administrator has afforded the applicant an opportunity for a hearing.

(d) Upon approving an application under this section, the Administrator shall certify to the Secretary of the Treasury the amount of the grant requested with respect to such project in such application, but in no event an amount greater than 65 per centum of the estimated cost of construction of the project, and shall designate the appropriation from which it shall be paid. Such certification shall provide for payment to the applicant or, if designated by the applicant, the State home for which such project is being constructed or any other agency or instrumentality of the applicant. Such amount shall be paid, in advance or by way of reimbursement, and in such installments consistent with the progress of construction as the Administrator may determine and certify for payment to the Secretary of the Treasury. Funds paid under this section for the construction of an approved project shall be used solely for carrying out such project as so approved.

(e) Any amendment of any approved application shall be subject to approval in the same manner as an original application.

§ 5036. Recapture provisions

If, within twenty years after completion of any project for construction of facilities for furnishing nursing home care with respect to which a grant has been made under this subchapter, such facilities cease to be operated by a State, a State home, or an agency or instrumentality of a State principally for furnishing nursing home care to [war] veterans, the United States shall be entitled to recover from the State which was the recipient of the grant under this subchapter, or from the then owner of such facilities, 65 per centum of the then value of such facilities, as determined by agreement of the parties or by action brought in the district court of the United States for the district in which such facilities are situated.

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Subchapter IV—Sharing of Medical Facilities, Equipment, and Information

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§ 5052. Definitions

For the purposes of this subchapter—

(a) The term “research center” means an institution (or part of an institution), the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high quality diagnostic and treatment services for inpatients and outpatients.

(b) The term “specialized medical resources” means medical resources (whether equipment, space, or personnel) which, because of cost, limited availability, or unusual nature are either unique in the medical community or are subject to maximum utilization only through mutual use. *Such term also means emergency room medical*

resources which the Administrator determines are necessary for the treatment of veterans whose eligibility for medical services has been established under section 612(a) or 612(f) (1)(B) or (2) in medical emergencies which pose a serious threat to life or health but which would be unduly costly and duplicative to provide directly in a Veterans' Administration facility.

(c) The term "hospital", unless otherwise specified, includes any Federal, State, local, or other public or private hospital.

§ 5053. Specialized medical resources

(a) To secure certain specialized medical resources which otherwise might not be feasibly available, or to effectively utilize certain other medical resources, the Administrator may, when [he] the Administrator determines it to be in the best interest of the prevailing standards of the Veterans' Administration medical care program, make arrangements, by contract or other form of agreement, as set forth in [paragraphs] clauses (1) and (2) below, between Veterans' Administration hospitals and other hospitals (or other medical installations having hospital facilities) or medical schools or clinics in the medical community:

(1) for the mutual use, or exchange of use, of specialized medical resources when such an agreement will obviate the need for a similar resource to be provided in a Veterans' Administration *health care facility*; or

(2) for the mutual use, or exchange of use, of specialized medical resources in a Veterans' Administration *health care facility*, which have been justified on the basis of veterans' care, but which are not utilized to their maximum effective capacity.

The Administrator may determine the geographical limitations of a medical community as used in this section.

(b) Arrangements entered into under this section shall provide for reciprocal reimbursement based on a charge which covers the full cost of services rendered, supplies used, and including normal depreciation and amortization costs of equipment. Any proceeds to the Government received therefrom shall be credited to the applicable Veterans' Administration medical appropriation.

(c) Eligibility for hospital care and medical services furnished any veteran pursuant to this section shall be subject to the same terms as though provided in a Veterans' Administration *health care facility*, and provisions of this title applicable to persons receiving hospital care or medical services in a Veterans' Administration *health care facility* shall apply to veterans treated hereunder.

(d) *When a Veterans' Administration health care facility provides hospital care or medical services, pursuant to a contract or agreement authorized by this section, to an individual who is entitled to hospital or medical insurance benefits under subchapter XVIII of chapter 7 of title 42, such benefits shall be paid, notwithstanding any condition, limitation, or other provision in that title which would otherwise preclude such payment, in accordance with—*

(1) *rates prescribed by the Secretary of Health, Education, and Welfare, after consultation with the Administrator, and*

(2) *procedures jointly prescribed by the Secretary and the Administrator to assure reasonable quality of care and services and efficient and economical utilization of resources.*

to such facility therefor or, if the contract or agreement so provides, to the community health care facility which is a party to the contract or agreement.

§ 5054. Exchange of medical information

(a) The Administrator is authorized to enter into agreements with medical schools, hospitals, research centers, and individual members of the medical profession under which medical information and techniques will be freely exchanged and the medical information services of all parties to the agreement will be available for use by any party to the agreement under conditions specified in the agreement. In carrying out the purposes of this section, the Administrator shall utilize recent developments in electronic equipment to provide a close educational, scientific, and professional link between Veterans' Administration hospitals and major medical centers. Such agreements shall be utilized by the Administrator to the maximum extent practicable to create, at each Veterans' Administration hospital which is a part of any such agreement, an environment of academic medicine which will help such hospital attract and retain highly trained and qualified members of the medical profession.

(b) In order to bring about utilization of all medical information in the surrounding medical community, particularly in remote areas, and to foster and encourage the widest possible cooperation and consultation among all members of the medical profession in such community, the educational facilities and programs established at Veterans' Administration hospitals and the electronic link to medical centers shall be made available for use by *the* surrounding medical community. The Administrator may charge a fee for such services (on annual or like basis), at rates which **[he]** *the Administrator* determines, after appropriate study, to be fair and equitable. The financial status of any user of such services shall be taken into consideration by the Administrator in establishing the amount of the fee to be paid.

§ 5055. Pilot programs; grants to medical schools

(a) The Administrator may establish an Advisory Subcommittee on Programs for Exchange of Medical Information, of the Special Medical Advisory Group, established under section 4112 of this title, to advise **[him]** *the Administrator* on matters regarding the administration of this section and to coordinate these functions with other research and education programs in the Department of Medicine and Surgery. The Assistant Chief Medical Director **[for Research and Education in Medicine]** *charged with administration of the Department of Medicine and Surgery medical research program* shall be an ex officio member of this Subcommittee.

(b) The Administrator, upon the recommendation of the Subcommittee, is authorized to make grants to medical schools, hospitals, and research centers to assist such medical schools, hospitals, and research centers in planning and carrying out agreements authorized by section 5054 of this title. Such grants may be used for the employment of personnel, the construction of facilities, the purchasing of equipment when necessary to implement such programs, and for such other purposes as will facilitate the administration of this section.

(c) (1) There is hereby authorized to be appropriated an amount

not to exceed \$3 million for each fiscal year 1968 through 1971, and such sums as may be necessary for each fiscal year 1972 through 1975 for the purpose of developing and carrying out medical information programs under this section on a pilot program basis and for the grants authority in subsection (b) of this section. Pilot programs authorized by this subsection shall be carried out at Veterans' Administration hospitals in geographically dispersed areas of the United States.

(2) Funds authorized under this section shall not be available to pay the cost of hospital, medical, or other care of patients except to the extent that such cost is determined by the Administrator to be incident to research, training, or demonstration activities carried out under this section.

(d) The Administrator, after consultation with the Subcommittee shall prescribe regulations covering the terms and conditions for making grants under this section.

(e) Each recipient of a grant under this section shall keep such records as the Administrator may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

(f) The Administrator and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access, for the purpose of audit and examination, to any books, documents, papers, and records of the recipient of any grant under this section which are pertinent to any such grant.

§ 5056. Coordination with [programs carried out under the Heart Disease, Cancer, and Stroke Amendments of 1965] health services development activities carried out under the National Health Planning and Resources Development Act of 1974

The Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, coordinate programs carried out under this subchapter and programs carried out under *part F* of title [IX] XVI of the Public Health Service Act.

* * * * *

§ 5058. Coordination with programs carried out under title XI of the Social Security Act

(a) *The Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, attempt to coordinate the Professional Standards Review program carried out under part B of title XI of the Social Security Act and the comparable programs carried out by the Department of Medicine and Surgery to assess the quality of patient care in Veterans' Administration health care facilities. Such coordination shall include sharing of information with regard to norms of health care services developed on a regional and national basis and arrangements for joint memberships on entities established by the Department of Medicine and Surgery and entities established under such Act.*

(b) *Not later than one year after the date of enactment of this sec-*

tion, and annually thereafter, the Chief Medical Director shall report to the Congress on the effectiveness of such coordination in improving the evaluation of the quality of patient care provided by the Department of Medicine and Surgery and in achieving the purposes of the program carried out under such Act.

§ 5059. Reports on coordination with other programs

Not later than three months after the end of each fiscal year, the Chief Medical Director, through the Administrator, shall report to the Congress on all activities (and the results thereof) in which the Chief Medical Director or a designee, as a representative of the Veterans' Administration, has participated, as a result of a statutory requirement or otherwise, in an advisory or coordinating capacity with respect to programs carried out by other departments, agencies, or instrumentalities of the executive branch.

CHAPTER 82—ASSISTANCE IN ESTABLISHING NEW STATE MEDICAL SCHOOLS; GRANTS TO AFFILIATED MEDICAL SCHOOLS; ASSISTANCE TO HEALTH MAN-POWER TRAINING INSTITUTIONS

Subchapter I—Pilot Program for Assistance in the Establishment of New State Medical Schools

* * * * *

§ 5070. Coordination with public health programs; administration

(a) The Administrator and the Secretary of Health, Education, and Welfare shall, to the maximum extent practicable, coordinate the programs carried out under this chapter and the programs carried out under section 309 and titles VII, VIII, and IX of the Public Health Service Act.

(b) The Administrator may not enter into any agreement under subchapter I of this chapter or make any grant or provide other assistance under subchapter II or III of this chapter after the end of the seventh calendar year after the calendar year in which this chapter takes effect.

(c) The Administrator, after consultation with the special medical advisory committee established pursuant to section 4112(a) of this title, shall prescribe regulations covering the terms and conditions for entering into agreements and making grants under this chapter.

(d) Payments made pursuant to grants under this chapter may be made in installments, and either in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Administrator may determine.

(e) *In carrying out the purposes of this chapter, the Administrator may lease to any eligible institution for such consideration and under such terms and conditions as the Administrator deems appropriate, such land, buildings, and structures (including equipment therein) under the control and jurisdiction of the Veterans' Administration as may be necessary. The three-year limitation on the term of a lease prescribed in section 5012(a) of this title shall not apply with respect to any lease entered into pursuant to this chapter. Any lease entered into pursuant to this chapter may be entered into*

without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5). Notwithstanding section 321 of the Act entitled "An Act making appropriations for the Legislative Branch of the Government for the fiscal year ending June 30, 1933, and for other purposes", approved June 30, 1932 (40 U.S.C. 303b), or any other provision of law, a lease entered into pursuant to this chapter may provide for the maintenance, protection, or restoration, by the lessee, of the property leased, as a part or all of the consideration of the lease.

[e] (f) In making grants under this chapter, the Administrator shall give special consideration to applications from institutions which provide reasonable assurances, which shall be included in the grant agreement, that priority for admission to health manpower and training programs carried out by such institutions will be given to otherwise qualified veterans who during their military service acquired medical military occupation specialties, and that among such qualified veterans those who served during the Vietnam era and those who are entitled to disability compensation under laws administered by the Veterans' Administration or whose discharge or release was for a disability incurred or aggravated in line of duty will be given the highest priority. In carrying out this chapter and section 4101(b) of this title in connection with health manpower and training programs assisted or conducted under this title or in affiliation with a Veterans' Administration medical facility, the Administrator shall take appropriate steps to encourage the institutions involved to afford the priorities described in the first sentence of this subsection and to advise all qualified veterans with such medical military occupation specialties of the steps **[he]** the Administrator has taken under this subsection and the opportunities available to them as a result of such steps.

[f] (g) (1) Each recipient of assistance under this chapter shall keep such records as the Administrator shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such assistance, the total cost of the project or undertaking in connection with which such assistance is made or used, the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

(2) The Administrator and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of any assistance under this chapter which are pertinent to such assistance.

(h) *Not later than ninety days after the end of each fiscal year, the Administrator shall submit to the Congress a report on activities carried out under this chapter, including (1) an appraisal of the effectiveness of the programs authorized herein in carrying out their statutory purposes and the degree of cooperation from other sources, financial and otherwise, (2) an appraisal of the contributions of such programs in improving the quantity and quality of physicians and other health care personnel furnishing hospital care and medical services to veterans under this title, (3) a list of the approved but unfunded projects under this chapter and the funds needed for each such project, and (4) recommendations for the improvement or more effective*

tive administration of such programs, including any necessary legislation.

§ 5071. Declaration of purpose

The purpose of this subchapter is to authorize the Administrator to implement a pilot program under which [he] the Administrator may provide assistance in the establishment of new State medical schools at colleges or universities which are primarily supported by the States in which they are located if such schools are located in proximity to, and operated in conjunction with, Veterans' Administration medical facilities.

* * * * *

§ 5073. Pilot program assistance

(a) Subject to subsection (b) of this section, the Administrator may enter into an agreement to provide to any college or university which is primarily supported by the State in which it is located (hereinafter in this subchapter referred to as "institution") the following assistance to enable such institution to establish a new medical school:

[(1)] (1) The leasing to the institution, for such consideration and under such terms and conditions as the Administrator deems appropriate, of such land, buildings, and structure (including equipment therein) under the control and jurisdiction of the Veterans' Administration as may be necessary for such school. The three-year limitation on the term of a lease in section 5012(a) of this title shall not apply with respect to any lease entered into pursuant to this paragraph. Any lease made pursuant to this subchapter may be made without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5). Notwithstanding section 321 of the Act entitled "An Act making appropriations for the Legislative Branch of the Government for the fiscal year ending June 30, 1933, and for other purposes", approved June 30, 1932 (40 U.S.C. 303b), or any other provision of law, a lease made pursuant to this subchapter may provide for the maintenance, protection, or restoration, by the lessee, of the property leased, as a part or all of the consideration for the lease.】

[(2)] (1) The extension, alteration, remodeling, improvement, or repair of buildings and structures (including, as part of a lease made under paragraph (1), the provision of equipment) provided under paragraph (1) to the extent necessary to make them suitable for use as medical school facilities.

[(3)] (2) The making of grants to assist the institution to pay the cost of the salaries of the faculty of such school during the initial twelve-month period of operation of the school and the next six such twelve-month periods, but payment under this paragraph may not exceed an amount equal to—

(A) 90 per centum of the cost of faculty salaries during the first twelve-month period of operation,

(B) 90 per centum of such cost during the second such period,

(C) 90 per centum of such cost during the third such period,

(D) 80 per centum of such cost during the fourth such period,

(E) 70 per centum of such cost during the fifth such period,

(F) 60 per centum of such cost during the sixth such period, and

(G) 50 per centum of such cost during the seventh such period.

(b) (1) The Administrator may not enter into any agreement under subsection (a) of this section unless [he] *the Administrator* finds, and the agreement includes satisfactory assurances, that—

(A) there will be adequate State or other financial support for the proposed school;

(B) the overall plans for the school meet such professional and other standards as the Administrator deems appropriate;

(C) the school will maintain such arrangements with the Veterans' Administration medical facility with which it is associated (including but not limited to such arrangements as may be made under subchapter IV of chapter 81 of this title) as will be mutually beneficial in the carrying out of the mission of the medical facility and the school; and

(D) on the basis of consultation with the appropriate accreditation body or bodies approved for such purpose by the Commissioner of Education of the Department of Health, Education, and Welfare, there is reasonable assurance that, with the aid of an agreement under subsection (a) of this section, such school will meet the accreditation standards of such body or bodies within a reasonable time.

(2) Any agreement entered into by the Administrator under this subchapter shall contain such terms and conditions (in addition to those imposed pursuant to [subsections (a) (1) and] *section 5070(e)* of this title and subsection (b) (1) of this section) as [he] *the Administrator* deems necessary and appropriate to protect the interest of the United States.

(c) If the Administrator, in accordance with such regulations as [he] *the Administrator* shall prescribe, determines that any school established with assistance under this chapter—

(1) is not accredited and fails to gain appropriate accreditation within a reasonable period of time;

(2) is accredited but fails substantially to carry out the terms of the agreement entered into under this chapter; or

(3) is no longer operated for the purpose for which such assistance was granted,

[he] *the Administrator* shall be entitled to recover from the recipient of assistance under this chapter the facilities of such school which were established with assistance under this chapter. In order to recover such facilities the Administrator may bring an action in the district court of the United States for the district in which such facilities are situated.

* * * * *

Subchapter II—Grants to Affiliated Medical Schools

* * * * *

§ 5083. Grants

(a) Any medical school which is affiliated with the Veterans' Administration under an agreement entered into pursuant to [subchapter

IV of chapter 81 of [] this title may apply to the Administrator for a grant under this subchapter to assist such school, in part, to carry out, through the Veterans' Administration medical facility with which it is affiliated, projects and programs in furtherance of the purposes of this subchapter, except that no grant shall be made for the construction of any building which will not be located on land under the jurisdiction of the Administrator. Any such application shall contain such information in such detail as the Administrator deems necessary and appropriate.

(b) An application for a grant under this section may be approved by the Administrator only upon [his] *the Administrator's* determination that—

(1) the proposed projects and programs for which the grant will be made will make a significant contribution to improving the medical education (including continuing education) program of the school and will result in a substantial increase in the number of medical students attending such school, provided there is reasonable assurance from a recognized accredited body or bodies approved for such purposes by the Commissioner of Education of the Department of Health, Education, and Welfare that the increase in the number of students will not threaten any existing accreditation or otherwise compromise the quality of the training at such school;

(2) the application contains or is supported by adequate assurance that any Federal funds made available under this subchapter will be supplemented by funds or other resources available from other sources, whether public or private;

(3) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of, and accounting for, Federal funds expended under this subchapter; and

(4) the application provides for making such reports, in such form and containing such information, as the Administrator may require to carry out [his] *the Administrator's* functions under this subchapter, and for keeping such records and for affording such access thereto as the Administrator may find necessary to assure the correctness and verification of such reports.

Subchapter III—Assistance to Public and Nonprofit Institutions of Higher Learning, Hospitals and Other Health Manpower Institutions Affiliated With the Veterans' Administration to Increase the Production of Professional and Other Health Personnel

* * * * *

§ 5093. Grants

(a) Any eligible institution may apply to the Administrator for a grant under this subchapter to assist such institution to carry out, through the Veterans' Administration medical facility with which it is, or will become affiliated, educational and clinical projects and programs, matching the clinical requirements of the facility to the health manpower training potential of the eligible institution, for the expansion and improvement of such institution's capacity to train health manpower, including physicians' assistants, nurse practitioners, and

other new types of health personnel in furtherance of the purposes of this subchapter. Any such application shall contain a plan to carry out such projects and programs and such other information in such detail as the Administrator deems necessary and appropriate.

(b) An application for a grant under this section may be approved by the Administrator only upon **[his]** *the Administrator's* determination that—

(1) the proposed projects and programs for which the grant will be made will make a significant contribution to improving the education (including continuing education) or training program of the eligible institution and will result in a substantial increase in the number of students trained at such institution, provided there is reasonable assurance from a recognized accrediting body or bodies approved for such purposes by the Commissioner of Education of the Department of Health, Education, and Welfare that the increase in the number of students will not threaten any existing accreditation or otherwise compromise the quality of the training at such institution;

(2) the application contains or is supported by adequate assurance that any Federal funds made available under this subchapter will be supplemented by funds or other resources available from other sources, whether public or private;

(3) the application sets forth such fiscal control and accounting procedures as may be necessary to assure proper disbursement of, and accounting for, Federal funds expended under this subchapter; and

(4) the application provides for making such reports, in such form and containing such information, as the Administrator may require to carry out **[his]** *the Administrator's* functions under this subchapter, and for keeping such records and for affording such access thereto as the Administrator may find necessary to assure the correctness and verification of such reports.

Subchapter IV—Expansion of Veterans' Administration Hospital Education and Training Capacity

§ 5096. Expenditures to remodel and make special allocations to Veterans' Administration hospitals for health manpower education and training

Out of funds appropriated to the Veterans' Administration pursuant to the authorization in section 5082 of this title, the Administrator may expend such sums as **[he]** *the Administrator* deems necessary, not to exceed 30 per centum thereof, for (1) the necessary extension, expansion, alteration, improvement, remodeling, or repair of Veterans' Administration buildings and structures (including provision of initial equipment, replacement of obsolete or worn-out equipment, and, where necessary, addition of classrooms, lecture facilities, laboratories, and other teaching facilities) to the extent necessary to make them suitable for use for health manpower education and training in order to carry out the purpose set forth in section 4101(b), and (2) special allocations to Veterans' Administration hospitals and other medical facilities for the development or initiation of improved

methods of education and training which may include the development or initiation of plans which reduce the period of required education and training for health personnel but which do not adversely affect the quality of such education or training.

* * * * *

CHAPTER 85—DISPOSITION OF DECEASED VETERANS' PERSONAL PROPERTY

* * * * *

Subchapter I—Property Left on Veterans' Administration Facility

* * * * *

§ 5202. Disposition of unclaimed personal property

(a) Notwithstanding the provisions of section 5201 of this title, the Administrator may dispose of the personal property of such decedent left or found upon such premises as hereafter provided in this subchapter.

(b) If any veteran (admitted as a veteran) *or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title*, upon his last admission to, or during his last period of maintenance in, a Veterans' Administration facility, shall have designated in writing a person (natural or corporate) to whom he desires his personal property situated upon such facility to be delivered, upon the death of such veteran the Administrator or employee of the Veterans' Administration authorized by him so to act, may transfer possession of such personal property to the person so designated. If there exists no person so designated by the veteran or if the one so designated declines to receive such property, or if he has failed to request such property within ninety days after the Veterans' Administration mails to such designate a notice of death and of the fact of such designation, a description of the property, and an estimate of transportation cost, which shall be paid by such designate if required under the regulations hereinafter mentioned, or if the Administrator declines to transfer possession to such designate, possession of such property may in the discretion of the Administrator or his designated subordinate, be transferred to the following persons in the order and manner herein specified unless the parties otherwise agree as provided in this subchapter, namely executor or administrator, or if no notice of appointment received, to the spouse, child, grandchild, mother, father, grandmother, grandfather, brother or sister of the veteran. In case two or more of those named above request the property, only one shall be entitled to possession thereof and in order hereinbefore set forth, unless they otherwise agree in writing delivered to the Veterans' Administration. If claim is made by two or more such relatives having equal priorities, as hereinabove prescribed, or if there are conflicting claims the Administrator or his designee may in such case select the one to receive such possession, or may make delivery as may be agreed upon by those entitled, or may in his discretion withhold delivery from

them and require the qualification of an administrator or executor of the veterans' estate and thereupon make delivery to such.

(c) If the property of any decedent is not so delivered or claimed and accepted the Administrator or his designee may dispose of such property by public or private sale in accordance with the provisions of this subchapter and regulations prescribed by the Administrator.

(d) All sales authorized by this subchapter shall be for cash upon delivery at the premises where sold and without warranty, express or implied. The proceeds of such sales after payment of any expenses incident thereto as may be prescribed by regulations, together with any other moneys left or found on a facility, not disposed of in accordance with this subchapter, shall be credited to the General Post Fund, National Homes, Veterans' Administration, a trust fund provided for in section 725s (a) (45) of title 31. In addition to the purposes for which such fund may be used under the existing law, disbursements may be made therefrom as authorized by the Administrator by regulation or otherwise for the purpose of satisfying any legal liability incurred by any other employee in administering the provisions of this subchapter, including any expense incurred in connection therewith. Legal liability shall not exist when delivery or sale shall have been made in accordance with this subchapter.

(e) If, notwithstanding such sale, a claim is filed with the Administrator within five years after notice of sale as herein required, by or on behalf of any person or persons who if known would have been entitled to the property under section 5201 of this title or to possession thereof under this section, the Administrator shall determine the person or persons entitled under the provisions of this subchapter and may pay to such person or persons so entitled the proceeds of sale of such property, less expenses. Such payment shall be made out of the said trust fund, and in accord with the provisions of this section or section 5201 of this title. Persons under legal disability to sue in their own name may make claim for the proceeds of sale of such property at any time within five years after termination of such legal disability.

(f) Any such property, the sale of which is authorized under this subchapter and which remains unsold, may be used, destroyed, or otherwise disposed of in accordance with regulation promulgated by the Administrator.

* * * * *

Subchapter II—Death While Inmate of Veterans' Administration Facility

§ 5220. Vesting of property left by decedents

(a) Whenever any veteran (admitted as a veteran), or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title, shall die while a member or patient in any facility, or any hospital while being furnished care or treatment therein by the Veterans' Administration, and shall not leave surviving him any spouse, next of kin, or heirs entitled under the laws of his domicile, to his personal property as to which he dies intestate, all such property, including money and choses in action, owned by him at the time of

death and not disposed of by will or otherwise, shall immediately vest in and become the property of the United States as trustee for the sole use and benefit of the General Post Fund (hereafter in this subchapter referred to as the "Fund"), a trust fund prescribed by section 725(a) (45) of title 31.

(b) The provisions of subsection (a) are conditions precedent to the initial, and also to the further furnishing of care or treatment by the Veterans' Administration in a facility or hospital. The acceptance and the continued acceptance of care or treatment by any veteran (admitted as a veteran to a Veterans' Administration facility or hospital) shall constitute an acceptance of the provisions and conditions of this subchapter and have the effect of an assignment, effective at his death, of such assets in accordance with and subject to the provisions of this subchapter and regulations issued in accordance with this subchapter.

§ 5221. Presumption of contract for disposition of personalty

The fact of death of a veteran (admitted as such), *or a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title*, in a facility or hospital, while being furnished care or treatment therein by the Veterans' Administration, leaving no spouse, next of kin, or heirs, shall give rise to a conclusive presumption of a valid contract for the disposition in accordance with this subchapter, but subject to its conditions, of all property described in section 5220 of this title owned by said decedent at death and as to which he dies intestate.

* * * * *

PUBLIC LAW 94-123

SEC. 6. (a) (1) The amendments made by section 2 of this Act shall become effective on October 12, 1975.

(2) No agreement to provide special pay may be entered into pursuant to section 4118 of title 38, United States Code (as added by section 2(d) (1) of this Act), after **[October 11, 1976]** *June 30, 1977, or the expiration date of the authority contained in section 313 of title 37, United States Code, to provide special pay to physician medical officers in the uniformed services, whichever is later.*

(b) Except as provided in subsection (a) (1) of this section, the amendments made by this Act shall become effective beginning the first pay period following thirty days after the date of the enactment of this Act.

APPENDICES

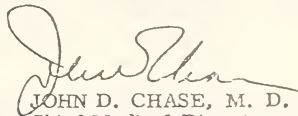
APPENDIX A

VETERANS ADMINISTRATION
Department of Medicine and Surgery
Washington, D. C. 20420
August 3, 1976

INTERIM ISSUE 10-76-21

- A. BASIC ADMINISTRATIVE ISSUE AFFECTED: DM&S Manual M-1, Part I, Chapter 17
- B. OTHER ISSUES AFFECTED: None
- C. REASON FOR ISSUE: To establish policy for admission to outpatient treatment by priorities; to define these priorities; and, to establish procedures for compliance with this policy.
- D. TEXT OF ISSUE: Chapter 17, M-1, Part I, is changed as follows:

After page 17-11, add new Section IX, "Priorities for Admission to Outpatient Treatment," see Attachment A.


JOHN D. CHASE, M. D.
Chief Medical Director

Attachment

Distribution: RPC: 1108
FD

II 10-76-21
August 3, 1976

Attachment A

SECTION IX. PRIORITIES FOR ADMISSION TO OUTPATIENT
TREATMENT

17.50 GENERAL

Placement of eligible veterans in an active outpatient status must be effectively managed in accordance with priorities established in this section to insure that the quality of service provided is maintained at a high level when the demand for these services exceeds the limits of resources available to the VA for this purpose. It applies to treatment to be provided in a VA medical facility or in a non-VA medical facility at VA expense.

17.51 POLICY

Admission to any of the outpatient programs described in sections II through VI and section VIII of this chapter, or to ambulatory care to obviate hospitalization, and for examinations as described in chapter 20 will be based on a professional determination of need for such treatment and will be scheduled in the following sequence of priority.

GROUP I

- a. Service-connected veterans requiring care for service-connected condition(s).
- b. Compensation and Pension Examinations (2507) and examinations for insurance purposes.
- c. Spanish-American War veterans requiring care for any condition.
- d. Service-connected veterans with a rating of 80% or more requiring care for an adjunct condition or nonservice-connected condition.
- e. Service-connected veterans requiring care for a condition adjunct to the service-connected condition.
- f. Veterans receiving additional compensation or allowance because of being permanently housebound or in need of regular aid and attendance requiring care for any medical condition.
- g. Veterans who have been found to be in need of vocational rehabilitation training, and such care is medically determined necessary for any of the reasons given in VAR 6036 (B).

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GROUP II

Veterans with compensable service-connected disabilities requiring care for nonservice-connected conditions, i. e., PBC, OPT-NSC, ambulatory care to obviate the need for hospitalization.

GROUP III

- a. Veterans in receipt of NSC pension with an additional allowance because of need of aid and attendance or being housebound when requiring medical care for NSC conditions.
- b. Veterans in receipt of NSC pension who are 65 years old or more in age when requiring medical care for NSC conditions.

GROUP IV

Nonservice-connected veterans requiring post-hospital care (OPT-NSC). (Includes veterans with noncompensable service-connected disabilities requiring OPT-NSC care for nonservice-connected conditions.)

GROUP V

Nonservice-connected veterans requiring pre-bed care (PBC). (Includes veterans with noncompensable service-connected disabilities requiring PBC for nonservice-connected conditions.)

GROUP VI

Nonservice-connected veterans requiring care to obviate need for hospitalization. (Includes veterans with noncompensable service-connected disabilities requiring care to obviate need for hospitalization for a nonservice-connected condition.)

GROUP VII

When it has been determined that staff and facilities are available and that eligible veterans will not be deprived of care to which they are entitled, outpatient care may be provided for the following persons: (a) Beneficiaries from other Federal agencies, (b) active or retired military personnel, (c) veterans of nations allied with the United States in World War I or II, (d) persons treated under sharing agreements.

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An effective centralized scheduling system is essential in the management of admissions to the Outpatient Treatment programs. Scheduling activities will be conducted as described in section I, this chapter. In addition, great care will be exercised not only to assure full use of available appointment periods, personnel and facilities, but also to assure that scheduling is done in a flexible manner to provide the meeting of unscheduled requirements for care of emergency cases and of service-connected veterans. In order to achieve this flexibility, the practice of overscheduling of appointments for the general medicine or other primary clinics, will be discontinued. This should allow for attending to the unscheduled requirements for care in the appointment periods which had been reserved for veterans who failed to keep their appointments.

17.52 PROCEDURES

a. The priority group to which candidates for admission to outpatient care belong will be identified. This identification will be prominently noted on documents appropriate to the type of patient involved, i.e., VAF 10-10 for new applicants, medical records for OPT-NSC, VAF 21-2507 for C&P examinations, etc. The medical records will be stamped with the legend "Priority Group ____." In the case of Group I veterans this stamp will be affixed directly above the Gold Label.

b. A veteran appearing at the reception activity seeking evaluation or treatment who does not have an appointment scheduled will be referred to the triage or general medicine clinic evaluation team in the following sequence, service-connected and Spanish-American War veterans, followed by nonservice-connected veterans in order of arrival. NOTE: Emergency cases, whether service-connected or not, will continue to be referred to the evaluation team on a top priority basis.

c. If the veteran requesting evaluation without a scheduled appointment is appearing for the first time, the reception activity will prepare a VA Form 10-10 containing only the veteran's name and address, social security number, branch of military service, service-status, and, name and address of the next of kin, for referral with the veteran to the evaluation team. Previous hospitalization, PBC, OPT-NSC, or ambulatory care records of a veteran who had previously been hospitalized or admitted to outpatient treatment but who comes in for evaluation or treatment without a scheduled appointment will be obtained for referral with the veteran to the evaluation team. Preparation of VA Form 10-10 or retrieval of previous records will be provided as expeditiously as possible so as not to delay the immediate referral of emergency cases to the evaluation team.

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d. The triage or general medicine clinic evaluation team will professionally determine whether the nature of the illness presented by the veteran:

- (1) requires hospital admission as an emergent, urgent, or general classification, or,
- (2) requires immediate admission to outpatient treatment and must be scheduled in the next appointment period available for his or her priority group on the same date as the evaluation, or
- (3) requires admission to outpatient treatment but can wait for scheduling in the next appointment period available for his or her priority groups in the future, i.e., within 90 days, or,
- (4) does not require admission to VA hospital or outpatient treatment, but requires referral to Social Work Service for review and counseling regarding use of non-VA health care resources;
- (5) does not require admission to hospital or outpatient treatment and may be dismissed.

The appropriate professional determination will be annotated in the veteran's records and returned to the reception activity for disposition.

e. The reception activity will make disposition as professionally indicated on the veteran's record:

- (1) In cases requiring admission to the hospital, the veteran will be admitted immediately as an emergency, or as a service-connected or Spanish-American War veteran, or as a non-emergent case if a bed is otherwise available.
- (2) In cases requiring admission to outpatient treatment on the same day of evaluation, the reception activity will contact centralized scheduling for an appointment in the time "slot" available the date of evaluation. These veterans will be scheduled in the sequence of priority listed in paragraph 17.51 above.

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- (3) In cases requiring admission to outpatient treatment by scheduling of an appointment in the future, i.e., within 90 days, the reception activity will contact centralized scheduling for an appropriate appointment. In some instances, notice of the date and time of the future appointment may have to be mailed to the veteran at a later date. This scheduling will also be done in the sequence of priority listed in paragraph 17.51 above.
- (4) Veterans not requiring VA hospitalization or outpatient treatment will be referred to Social Work Service or dismissed as recommended by the evaluation team.

f. Requests for C&P examinations, after classifications as to professional elements to conduct the examination have been entered on VA Form 21-2507, will be forwarded directly to the centralized scheduling activity for scheduling of an appointment in keeping with Group I priority assigned to these type of examinations.

g. Bed services discharging patients to NBC or OPT will contact centralized scheduling for an appointment as described in section I, this chapter. Appointments for these veterans will also be made in the sequence of priority shown in paragraph 17.51.

h. Veterans who are in a treatment category, such as ambulatory care, and are subsequently placed in another treatment category, such as PBC, will be reclassified to the appropriate group, i.e., from Group VI to Group V.

APPENDIX B

TELEGRAPHIC MESSAGE

NAME OF AGENCY VACO - WASH., D. C.		PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION				
ACCOUNTING CLASSIFICATION		DATE PREPARED 7/1/76	TYPE OF MESSAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> BOOK <input type="checkbox"/> MULTIPLE-ADDRESS				
FOR INFORMATION CALL							
NAME JOSEPH ERWIN (136F)		PHONE NUMBER 2851					
THIS SPACE FOR USE OF COMMUNICATION UNIT							
MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)							
<p>TO:</p> <p>DIRECTORS, VA HOSPITALS, DOMICILIARY, VA OUTPATIENT CLINICS AND REGIONAL OFFICES WITH OUTPATIENT CLINICS</p> <p>INFO: ALL DPC'S AND MEDICAL DISTRICT ²⁷₂₈, VARO, SAN FRANCISCO</p> <p>RESTRICT TRANSMISSION TO 59 CHARACTERS PER LINE</p> <p>00/136 THIS IS INTERIM ISSUE 10-76-²⁰</p> <p>A. BASIC ADMINISTRATIVE ISSUE AFFECTED: M-1, PART I, CHAPTER 25</p> <p>B. OTHER ISSUES AFFECTED: MP-1, PART II, CHAPTER 3</p> <p>C. REASON FOR ISSUE: (1) TO PROVIDE THAT REIMBURSEMENT FOR COSTS OF BENEFICIARY TRAVEL OF CERTAIN VETERANS WILL NOT EXCEED THE COSTS OF THE MOST ECONOMICAL COMMON CARRIER, AND (2) THE INABILITY STATEMENT TO DEFRAY COST OF BENEFICIARY TRAVEL WILL BE READ TO CERTAIN VETERANS.</p> <p>D. TEXT OF ISSUE: DMS MANUAL M-1, PART I, CHAPTER 25 IS CHANGED AS FOLLOWS:</p> <p><u>PAGE 25-1</u>: DELETE "25.03-25.10 (RESERVED)" AND INSERT THE FOLLOWING:</p> <p>"25.03 CONTROLS</p> <p>a. VETERANS WILL NOT BE REIMBURSED FOR COSTS OF TRANSPORTATION EXPENSES IN EXCESS OF COST OF THE MOST ECONOMICAL COMMON CARRIER PLUS THE COSTS OF AUTHORIZED MEALS AND LODGING INCURRED WHILE EN ROUTE.</p> <p>EXCEPTION:</p>							
		<table border="1"> <tr> <td>PAGE NO.</td> <td>NO OF PGS</td> </tr> <tr> <td>1</td> <td>3</td> </tr> </table>	PAGE NO.	NO OF PGS	1	3	SECURITY CLASSIFICATION
PAGE NO.	NO OF PGS						
1	3						

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO:	SECURITY CLASSIFICATION				
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> BOOK <input type="checkbox"/> MULTIPLE ADDRESS				
FOR INFORMATION CALL						
NAME	PHONE NUMBER					
THIS SPACE FOR USE OF COMMUNICATION UNIT						
MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)						
<p>TO:</p> <p>(1) VETERAN'S PHYSICAL OR MENTAL CONDITION IS SUCH THAT IT IS MEDICALLY DETERMINED THAT COMMON CARRIER IS NOT FEASIBLE NOR APPROPRIATE.</p> <p>(2) COMMON CARRIER FACILITIES ARE NOT FEASIBLY AVAILABLE.</p> <p>b. VETERANS NOT IN RECEIPT OF PENSION REQUIRING PRE-HOSPITAL (INCLUDING AMBULATORY CARE TO OBTAIN THE NEED FOR HOSPITALIZATION) OR POST-HOSPITAL (VA REGULATIONS 6060 (E) AND (F)) CARE FOR A NON-SERVICE CONNECTED CONDITION AND WHO ARE REQUESTING TRANSPORTATION AT VA EXPENSE WILL BE REQUIRED TO EXECUTE A VA FORM 10-2323, REQUEST FOR TRANSPORTATION AT VA EXPENSE DUE TO INABILITY TO PAY COSTS FOR EACH TRIP TO OR FROM A VA MEDICAL INSTALLATION. THE VA EMPLOYEE ASSISTING THE VETERAN IN COMPLETING THE REQUEST WILL:</p> <p>(1) ADVISE THE VETERAN OF THE ESTIMATED COST OF SUCH TRAVEL.</p> <p>(2) VERBALLY REVIEW THE FOLLOWING TEXT WITH THE VETERAN BEFORE HE/SHE SIGNS VA FORM 10-2323:</p> <p>"DO YOU HEREBY SWEAR (OR AFFIRM) THAT YOU ARE UNABLE TO PAY THE COSTS OF YOUR TRANSPORTATION AND THAT YOU THEREBY REQUEST THAT THE VA FURNISH YOU TRANSPORTATION AT VA EXPENSE?"</p>						
<table border="1"> <tr> <td>PAGE NO.</td> <td>NO. OF PGS.</td> </tr> <tr> <td>2</td> <td>3</td> </tr> </table>		PAGE NO.	NO. OF PGS.	2	3	SECURITY CLASSIFICATION
PAGE NO.	NO. OF PGS.					
2	3					

TELEGRAPHIC MESSAGE

NAME OF AGENCY		PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION		DATE PREPARED	TYPE OF MESSAGE <input type="checkbox"/> SINGLE <input type="checkbox"/> BOOK <input type="checkbox"/> MULTIPLE ADDRESS
FOR INFORMATION CALL			
NAME	PHONE NUMBER		
THIS SPACE FOR USE OF COMMUNICATION UNIT			
MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)			
<p>TO:</p> <p>(NOTE: IF THE VETERAN ANSWERS IN THE NEGATIVE, TRANSPORTATION AT VA EXPENSE WILL NOT BE FURNISHED.)</p> <p>"YOU ARE ADVISED THAT IF YOU KNOWINGLY MAKE A FALSE STATEMENT OF ANY MATERIAL FACT ca IN CONNECTION WITH THIS STATEMENT, YOU MAY BE SUBJECT TO PROSECUTION."</p> <p>EXCEPTION: VETERANS HAVING A SERVICE CONNECTED DISABILITY OR VETERANS 65 YEARS OF AGE OR OVER REQUIRING CARE OR EXAMINATION FOR NON-SERVICE CONNECTED DISABILITY ARE EXEMPTED FROM THE PROVISIONS OF SUBPARAGRAPH b., ABOVE.</p> <p>c. NOTWITHSTANDING THE SPECIAL PROVISIONS IN SUBPARAGRAPH b., ABOVE, THE PROVISIONS AND LIMITATIONS PROVIDED FOR IN VA REGULATIONS 6100, 6101 APPLY TO ALL VETERANS.</p> <p>25.04-25.10 (RESERVED)."</p> <p>136F/10A THIS IT WILL NOT BE CONFIRMED WITH A PRINTED ISSUE. 136F/10</p> <p><i>John P. [Signature]</i></p> <p>JUL 26 1976</p>			
JERWIN:dw 136F 136 13 10A		PAGE NO. 3	NO. OF PGS 3
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